



Feasibility Study of the Privatization of the Alaska Psychiatric Institute

Final Report

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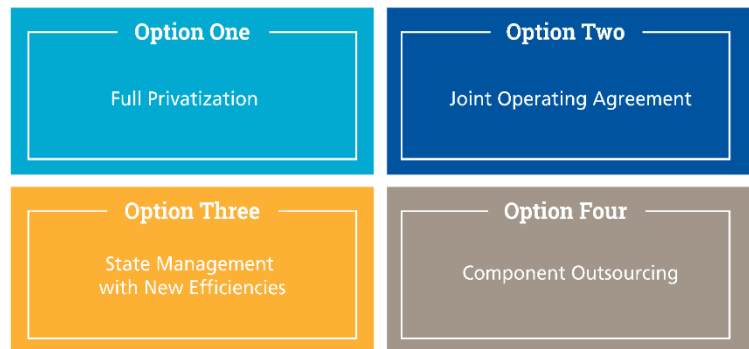
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1.0. EXECUTIVE SUMMARY

The Department of Health and Social Services (DHSS), in cooperation with the Alaska Mental Health Trust Authority (AMHTA), contracted with Public Consulting Group, Inc. (PCG) to conduct a privatization feasibility study of the Alaska Psychiatric Institute (API), the safety net provider of inpatient psychiatric care for the entire state and Alaska's only state-run psychiatric hospital. The goal of this study was to determine whether privatization of the facility could serve as a viable means for improving service delivery at the hospital and whether privatization has the potential to generate cost savings to the State without diminishing the quality of care delivered by the hospital.

This study offers a comprehensive analysis of privatization's estimated costs and benefits to the State, and encompasses a review of the State's legal obligations, estimated financial savings, service delivery efficiencies, enhanced quality of care and patient outcomes, and possible impacts on other aspects of Alaska's behavioral health system, including its correctional system and network of community service providers. PCG's study also evaluates the feasibility of privatizing API within a broader context of recent state hospital privatization efforts across the country, along with additional research on privatization outcomes in other types of facilities.

PCG developed four major options to consider for privatizing API. **Full Privatization** involves a private contractor assuming all operational aspects of API. The State would retain ownership of API's land and capital assets, and would either lease the facility to the contractor or hire the private provider as a property manager. In this option, the State's responsibilities in managing API would be restricted to its role as a contract administrator, providing oversight and monitoring the contractor's performance.



As a variation of full privatization, a **Joint Operating Agreement** does not differ substantially from the first option in estimated financial impact or responsibility for service delivery, but sets up privatization on a legal basis distinct from full privatization, in which privatization would be achieved by creating a new legal entity through an agreement between a private provider and DHSS, implemented either as a public corporation similar to AMHTA, or a 501 (C)(3) private, non-profit corporation.









The third option, **State Management with New Efficiencies**, is not so much a privatization option as an alternative to privatization that considers the impact of implementing the changes in staffing and business and service delivery process that would likely occur under a private operator, but assuming continued State management. This option explores what sorts of efficiencies can be achieved within the present management structure, without taking on the risks involved in the contracting process.

The final option, **Component Outsourcing**, analyzes individual components of the hospital that could be outsourced without diffusing administrative responsibilities or fragmenting service delivery or hospital operations. In each of the Component Outsourcing models developed by PCG, the State would retain overall operational responsibilities, but would contract out some or all of the facility's service delivery and operational functions. Noting that some functions, such as food services, are already contracted out to private vendors, PCG identified five distinct hospital components for further analysis:

- *Communication Center*: the hospital's front desk, providing security and reception functions;
- *Facility and Material Management*: the hospital's maintenance and environmental services staff;
- *Psychiatric and Medical Services*: the hospital's psychiatry and other physician personnel;
- *Nursing Services*: Registered Nurse (RN), Psychiatric Nurse Assistant (PNA) and nursing administrators;

- *Comprehensive Outsourcing*: virtually all of the hospital's non-administrative personnel.

The table below summarizes PCG's findings and recommendations for each of the privatization options developed for cost-benefit analysis:

Privatization Option	Feasibility	Findings and Recommendations
1: Full Privatization		Cost-benefit analysis revealed that, even after significant staff reduction, when all transition costs, contract monitoring costs, and provider margins are considered, this option proves to be more expensive to the state over a likely 5-year contract period. The additional staff reductions needed for budget neutrality would likely diminish the quality of service delivery.
2: Joint Operating Agreement		As a variation of full privatization, this option failed to generate cost savings for the same reasons.
3: State Management		Cost-benefit analysis showed that implementing greater efficiencies in administrative functions and nursing staffing patterns could deliver the greatest amount of cost savings of all the options.
4a: Communication Center		While this option involves relatively few hospital personnel, expected changes to compensation and the need for fewer staff under a private contractor would yield the highest percentage of savings for any of the options. These services could also be supplied by a viable marketplace of competing vendors.
4b: Facility and Material Management		This option involves roughly a tenth of hospital personnel and appears to deliver only modest cost savings. However, like security services, these maintenance and environmental services can be readily procured from a viable marketplace of vendors.
4c: Psychiatric and Medical Services		Unlike many categories of hospital staff, levels for psychiatric and medical staff are not typically reduced under privatization, nor is their compensation significantly decreased. In many cases, private entities will increase compensation to better support recruitment and retention of these scarce personnel. While these changes may improve service delivery, they do not yield cost savings. Aside from the potential for increased cost, PCG also cautions against privatizing these services due to concerns over a lack of clear providers, aside from locum tenens agencies.
4d: Nursing Services		From a fiscal perspective, nursing services are a potentially fruitful area for privatization, due to the fact that nursing staff make up 58% of all API personnel, with the greatest potential for savings through staff reductions and changes to benefits and compensation levels. While cost-benefit analysis showed that modest staff reductions—and associated cost savings—could be achieved without diminishing service delivery, it is not clear that a private provider could significantly lower overall compensation levels for nursing personnel without affecting recruitment and retention. Nor is it clear that a robust marketplace for these services exists in Alaska. Many of the identified improvements in nursing services could also be implemented under current state management.
4e: Comprehensive Outsourcing		Cost-benefit analysis revealed that this option failed to produce cost savings, making it infeasible on fiscal grounds. The higher cost was due largely to expense of privatizing psychiatric services.

The study details the service delivery benchmarks and cost estimation methodologies used by PCG to arrive at our recommendations. For the most part, our benchmarks for measuring the potential impact of staffing reductions on service delivery were derived from a combination of industry standards on appropriate nursing ratios as well as a series of staffing comparisons with other small, acute care peer hospitals. These benchmarking methods are discussed in detail in Section 7.2.

The cost considerations informing PCG's fiscal analysis are similarly detailed in Section 7.3-7.5. We believe our projected costs for each privatization option are comprehensive. They include a series of costs for private providers that are not currently internalized by API, such as legal costs and workers' compensation costs, as well as costs currently borne by API that would likely be absorbed by the wider enterprise under private management, such as expenditures related to information technology and quality improvement. PCG's fiscal analysis models likely changes to salary and benefit costs, as well as how a private contractor would be likely to regulate overtime pay. In our baseline comparison, PCG also includes significant costs that API will incur in the near future, when it will need to upgrade its electronic medical record (EMR) system. By the same token, we have been diligent in attempting to estimate additional transition costs the State would incur through contracting, such as additional liabilities to the State's retirement fund as well as ongoing procurement and contract monitoring costs.

Based on these analyses, PCG's assessment is that a blended approach to privatization is in the best interest of API and the State. Our findings demonstrate that continued State management is not only the most advantageous route for generating overall cost savings, but that it also avoids many of the risks involved in contracting out the management of critical public infrastructure. However, this alternative is also compatible with a number of the outsourcing options under review, including privatization of the communication center and facility and materials management. It is probable that savings can be maximized by privatizing some or all of these non-core services, with direct care services remaining under state management to prevent harm to service delivery or quality outcomes.

2.0. BACKGROUND AND APPROACH

2.1. Study Overview

In April 2016, the Alaska Legislature passed Senate Bill 74 (SB 74), mandating an analysis of the feasibility of privatizing services at the Alaska Psychiatric Institute (API), Alaska's single state-run psychiatric hospital. This study is a part of a larger set of efforts established in the bill to increase access to behavioral health and reduce the cost of care in Alaska. The Department of Health and Social Services (DHSS), in cooperation with the Alaska Mental Health Trust Authority (AMHTA), contracted with Public Consulting Group, Inc. (PCG) to conduct the API privatization feasibility study, with the goal of determining whether privatization of the facility could be a viable means for improving service delivery at the hospital as well as for producing cost savings to the State without diminishing the quality of care.

The primary objective of this privatization feasibility study is to identify a range of options for privatization with the potential for delivering greater value to the State of Alaska than current state management of services. This study offers a comprehensive analysis of privatization's likely costs and benefits to the State, and encompasses a review of the State's legal obligations, estimated financial savings, service delivery efficiencies, enhanced quality of care and patient outcomes, and impacts on the correctional system and community service providers. The study also evaluates the feasibility of privatizing API within a broader context of recent state hospital privatization efforts across the country, along with additional research on privatization outcomes in other types of facilities.

API is Alaska's only state-run psychiatric hospital, and thus, serves as the safety net provider of inpatient psychiatric care for the entire state, fulfilling the State's statutorily mandated obligation to ensure the availability of inpatient care for all Alaskans. Overseen by the DHSS Division of Behavioral Health (DBH), API is a 24-hour, 80-bed, Joint Commission-accredited inpatient psychiatric care facility employing roughly 250 permanent staff located in Anchorage, Alaska. API is responsible for treatment for the most acute phase of psychiatric illness when hospitalization is medically necessary, and is also a treatment facility of last resort for patients who are difficult to place in other settings within the community. The inpatient units within API range in size from 10 to 26 beds. Fifty (50) beds are allocated to adult acute psychiatric admissions. In addition to the adult acute units, API has a 10-bed, medium-security, forensic unit; a 10-bed adolescent unit (ages 13-17); and a 10-bed unit to meet the needs of our extended-care and / or difficult-to-place patients.

API lies at the center of a fragile network of behavioral health services in the State. With state suicide¹ and substance abuse² rates considerably higher than the national average, coupled with limited options for quality treatment, particularly in remote villages, improving the behavioral health system continues to be an area of focus and intensive concern for Alaskans. Despite the geographic expansiveness of Alaska, the tele-behavioral and forensic psychiatric expertise provided by API renders it as central to the service systems of even the most remote communities as it does to the larger, nearby communities of Anchorage, Kenai, and the Matanuska-Susitna Valley.

In discussions with stakeholders across the behavioral health system, it was apparent that interest in the feasibility of privatization stems from a range of concerns focused not only on trends related to the cost of inpatient care in Alaska, but also on the challenges of access to care in the State and the interest in improving the quality of service delivery at API. For a number of years, dramatic patient re-admission rates to the hospital, combined with increasing census pressure, shortening lengths of stay, and high workplace injury rates, have led many decision-makers to raise the question of whether management alternatives could improve these trends at API. In addition to these concerns, the State's budgetary constraints are a strong motivation for examining the

¹ http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/AKSuicideStatistics.pdf

² <http://dhss.alaska.gov/dbh/Pages/Prevention/programs/substanceabuse/default.aspx>

feasibility and desirability of privatization. While the State of Alaska's Medicaid spending is predicted to grow a little more than eight percent annually over the next 14 years³, the cost of inpatient psychiatric care has itself already grown considerably. API's annual budget has risen from roughly \$20 million to \$34 million in the last decade, and continues to be funded in large part by scarce dollars from Alaska's General Fund and from the State's Medicaid Disproportionate Share Hospital (DSH) payments. As the State reviews its spending, privatization no doubt presents itself as a possible solution to containing costs while still providing critical mental health services to Alaskans. With this understanding of the budgetary and service delivery issues facing API, PCG has sought to assess the current operational state of API and identify key areas within the facility and the State's mental health system most likely to be impacted by and benefit from privatization.

2.2. Study Method

This study strives to provide a comprehensive assessment of cost, quality, access, and state legal responsibilities. To accomplish these tasks successfully, PCG developed an approach to address the scope of work outlined in the procurement and detailed in the preceding section. The approach has seven main steps, as identified in the graphic below, each of which builds upon the previous step. PCG's method focused on establishing solid baseline and comparative models that create an accurate picture of the financial and programmatic elements of operations within API. PCG's approach combines qualitative and quantitative data collected from stakeholder interviews and public forums, a review of research literature and recent privatization efforts in other states, as well as API's historical financial and service delivery records. From these, we produced a set of analyses designed to assess the following:

- The State's legal obligations;
- All costs associated with service delivery and facility operations under the various privatization options;
- The role of API in Alaska's behavioral health and medical care systems;
- The quality of care in various privatization options;
- Transferring responsibility for deferred maintenance, on-going maintenance, and repair of the physical plant and land to a private operator;
- The history of privatization of public psychiatric hospitals across the country, including evidence based evaluations and key challenges.

1. Project Initiation: PCG began the project with a comprehensive project kick-off meeting that included key stakeholders to review the project work plan, develop detailed list of contacts, conduct preliminary interviews, and finalize the project schedule.

2. Data Collection: To conduct a comprehensive review of API, PCG utilized data and information from both API, as well as relevant state Medicaid reports and policy.

3. Stakeholder Input: PCG, in partnership with DHSS and API, identified key stakeholders in the privatization efforts and conducted on-site visits to gather stakeholder input.

³ http://dhss.alaska.gov/fms/Documents/MESA_2030.pdf

4. Policy Analysis: PCG conducted a comprehensive policy analysis that focused on two areas: review of both the State's legal obligations related to the provision of psychiatric hospital services and their transferability, and a review of other state's psychiatric hospital privatization efforts.

5. Baseline Model Development: PCG developed a psychiatric hospital baseline model through assessment of current operations, programs, services, and financials for API. The development of the baseline model helped define API's current state and how it compares to both privatized and public psychiatric hospitals.

6. Comparative Model Development: PCG developed comparative models based on peer facilities to illustrate the range of costs for services and key operating metrics for similar facilities across the country. In performing this detailed analysis of each facility, PCG was able to create a side-by-side comparison of standardized data.














7. Privatization Option Development: Following the baseline and comparative model development, PCG developed various privatization scenarios available to the state for privatizing API. PCG considered the following when developing scenarios: costs to the state, costs to the private entity, savings to the state, and quality of services.

In the report that follows, the findings produced from each stage of the feasibility study are laid out in order. The report begins with a summary of the issues that emerged out of conversations with stakeholders, illustrating the range of stakeholder involvement in the process as well as a constellation of concerns around costs and service delivery at API. Following this discussion, PCG reviews the major findings from our literature review, detailing privatization outcomes in cases similar to the transitions proposed for API, including privatization efforts in prison facilities and general hospitals. The study also incorporates a survey of recent privatization efforts in other states, highlighting important lessons learned for Alaska from both successful and failed initiatives across the country.

Informed by this research, PCG's baseline models highlight the salient financial and service delivery characteristics of API in comparison to other psychiatric hospitals, both large state hospitals—to which API is often misleadingly compared—as well as a set of small peer state hospitals of similar scale and service populations. These analyses serve as the background and source data for PCG's proposed privatization options, which are described in Section 8.1 of the report. In detailing the different scopes and assumptions for each option, PCG discusses overall legal requirements as well as relevant capital cost considerations. After providing a thorough cost-benefit analysis of each privatization option, the report concludes with a detailed set of recommendations based on the cost-benefit findings.

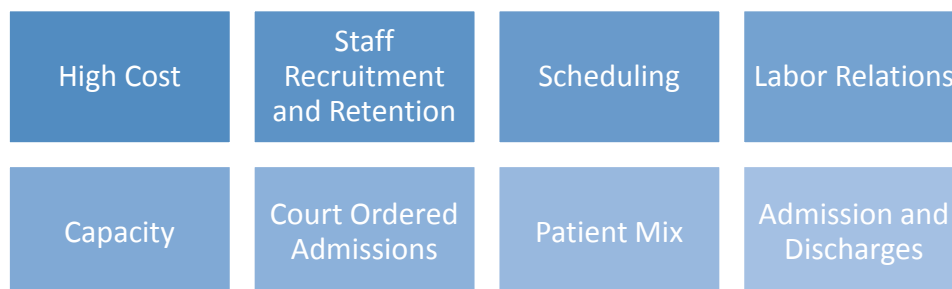
3.0. STAKEHOLDER COMMENT

As an initial component of the privatization feasibility study, PCG conducted in-person and telephonic stakeholder interviews. These interviews took place on-site in Juneau, Anchorage, Fairbanks and the Matanuska-Susitna Valley. In addition to the one-on-one interviews, PCG along with DHSS staff hosted a public town-hall meeting to gather community feedback on August 25, 2016 in Anchorage. PCG identified and scheduled interviews with stakeholders from the following groups:

	Alaska Psychiatric Institute
	Alaska Legislature
	Department of Health and Social Services
	Alaska Mental Health Trust Authority
	Department of Corrections
	Department of Administration
	Department of Law
	Alaska Court System
	Tribal and Non-Tribal Community Behavioral Health Providers
	Tribal and Non-Tribal Community Hospitals
	Advocacy Groups and Advisory Boards
	Labor Unions
	Trade Associations

Through the interviews, PCG aimed to identify relevant contextual information related to SB 74, and the State's interest in privatization of API. The purpose of the stakeholder interviews was to gain a comprehensive understanding, which included, but was not limited to gaining a better understanding of API and its role in Alaska's mental health system, and to guiding PCG in the development of more targeted analyses. Through these interviews, PCG noted the following reoccurring themes related to API: key issues, potential areas for privatization, potential concerns of privatization and potential benefits of privatization.

The key issues at API were highlighted across all stakeholder interviews, highlighting a comprehensive list of issues that ranged from cost, policy, service delivery and quality of care. From these interviews we were able to identify the following themes:



High Cost

Stakeholders reported that API's costs have continued to grow over the last decade. From this, there was a common perception that the high costs were largely related to staffing, specifically premium pay including overtime, swing, weekend and graveyard shift differentials, and injury leave. Furthermore, travel expenses related to transporting clients to and from the facility are also high and there is also high variability in ancillary medical charges from year to year, which are hard to predict. It is common for patients to come to API in poor medical condition, often requiring expensive medical services in addition to mental health services. As the facility begins to age, capital costs related to building maintenance have also been increasing. For example, after a recent Joint Commission inspection, as a safety issue, it was suggested that API would need to replace all the toilets in patient rooms and API is beginning to replace aging kitchen appliances in the near future.

Staff Recruitment and Retention

Stakeholders reported that hiring and retaining qualified staff is difficult in Alaska, and particularly at API. Due to Alaska's location, the State is unable to recruit and re-locate providers from neighboring states as easily as other states. The diminished labor pool also contributes to increased competition within the State to recruit and retain qualified employees among area providers. While it was noted that the facility is fully staffed, one or two resignations of psychiatrists, RNs or mid-level practitioners can cause operational deficiencies including temporary bed closures. A main barrier to staff retention reported was the current compensation levels for providers at API. According to data gathered by the Medical Group Management Association, compensation at API is up to 30% lower than that of the private sector. Paired with the strenuous nature of working in an acute psychiatric facility, providers at API often leave to work in private sector area hospitals where they will receive more compensation and have more stable schedules. Some stakeholders suggested that further action be taken to improve retention. Historically, API has also filled vacancies through the use of locum tenens. However, this has proven to be problematic due to the substantially higher costs of locum tenens compared to regular staff, despite the lower quality of care often provided by locum tenens physicians. While API has recently ended the use of contracted providers, lower compensation relative to the local competition will remain a barrier to hiring and keeping the necessary clinical staff. As seen in November 2015, when the Katmai unit temporary closed, an insufficient staff can have serious implications on service delivery.

Staff Scheduling

Multiple stakeholders suggested that API's current staff are not optimally scheduled to provide high quality and cost-effective care to Alaskans. On the one hand, it was noted that staffing needs can be highly variable at the hospital, due to the fluctuations in the number of patients who require close observation for suicidal, dangerous, or assaultive behavior. These patients require a 1:1 staffing ratio at minimum and sometimes more. Depending on the number of patients, elevated staffing levels can require an additional 5-6 staff per day. Because of the acute nature of treatment at API, this can cause difficulty in forecasting staffing needs and can lead to costly reactive scheduling. While it was generally felt that the facility is adequately staffed, various inefficiencies were noted in how staff are scheduled to provide coverage of the hospital's treatment units.

Currently, nursing staff are scheduled in a way that causes overlap between shifts to allow for transition of duties. These overlaps are believed to be costly and unnecessary. These concerns were corroborated by multiple parties, including a very recent report provided by DHSS to PCG by the Western Interstate Commission for Higher Education (WICHE) on API's Nursing Administration; PCG was notified that there are current plans to implement changes to decrease shift overlap and reduce costs. Currently, there are no agreements in place between the State and the various collective bargaining units that would restrict API from changing nursing schedules to a 12 hour on, 12 hour off model. This is predicted to help control staffing costs. Several stakeholders also commented on deficiencies in the way that API is scheduling providers during weekends. They noted that admitting patients during the weekend has been a challenge in the past due to the facility being short-staffed. These stakeholders believed that scheduling around normal business hours is not responsive to Alaskans experiencing a psychiatric crisis.

Labor Relations

PCG understands that any privatization scenario that impacted API staff would likely involve the Alaska State Employee Association, Alaska Public Employee Association, and the Public Employees Local 71. We are aware that if privatization is recommended, the collective bargaining units will have 30 days to review and present an alternate plan. Some advocates expressed concerns related to disciplinary action of API staff under the current agreements. Some felt that complaints related to use of restraints and excessive force were not being handled properly and offending personnel were being protected by their bargaining unit. API staff's ability to press charges on patients was another controversial area. Opponents of this practice suggest that this simply cycles patients from the civil units to the forensic units.

Capacity

Another recurring theme among all parties interviewed is that Alaska does not have the necessary system capacity to fully provide care to Alaskan's needing mental health services. In the last three decades, API's capacity has been halved from 160 beds to 80 beds. This was done with the plan of increasing state-wide capacity with the addition of 50 acute care beds through private Designated Evaluation and Treatment (DET) hospitals. While there are 12 beds available at Bartlett Regional Hospital in Juneau and 20 at Fairbanks Memorial Hospital in Fairbanks, the state-wide census has been continually increasing. Alaska Regional has indicated interest in opening a 12 bed psychiatric unit, which could potentially help alleviate the current capacity concerns. Regardless, the current state-wide capacity, and API's capacity in particular are not viewed as sufficient. Furthermore, there appears to be diminishing out-patient resources available in the state, which further increases the demand for inpatient services. Other than inpatient bed volume at API and throughout the State, there are several other factors driving capacity issues at API. Court ordered competency evaluations and restorations for forensic patients further exacerbate census pressure, as the hospital must quickly make bed-space available. Furthermore, due to a lack of other available resources in the State, some patients being admitted at API have co-occurring developmental disabilities, in which acute inpatient psychiatric care is not the most appropriate setting of care.

Court Ordered Admissions

In 2011, the Director of API at the time changed admission policies to require a court order instead of a Peace Officer Application (POA) which had been traditionally used. At the time, this was seen as a way to curb high utilization rates, but its actual impact was to greatly increase the involvement of the court system statewide in reviewing petitions for hospitalization for psychiatric evaluations and essentially had no impact on API's admission rates. API has also borne the burden of providing forensic restorations. This has caused long waits for patients needing admission to API's forensic unit, which only has a capacity of 10 beds. API's civil units are also routinely near maximum capacity. This has caused various issues related to Title 47s, or involuntary commitments. Furthermore, it should be noted that API's providers, as well as physicians at the two DET hospitals, are often

required to testify when petitions for 30 day patient commitments have been filed, which reduces time with patients and increases costs for the facilities. Court time and the cost of attending legal commitment proceedings are a possible barrier discouraging private hospitals from becoming psychiatric evaluation and treatment facilities. As one stakeholder noted, a private hospital would have a difficult time accounting for time spent in legal proceedings, using standard physician productivity measures. Currently, there are a number of initiatives for revising State commitment statutes that could impact API in the near future, as well as an examination of potential options for competency evaluation and restoration within the community setting.

Patient Mix

As the only public psychiatric hospital in Alaska, API acts as a catch all for difficult to place patients. Individuals with co-occurring developmental disabilities (DD) or Alzheimer Disease and Related Disorders (ADRD) are being cared for at API due to a lack of other resources. As an acute psychiatric facility, API is not an appropriate setting for this population of patients. Furthermore, since DD and ADRD are not acute psychiatric symptoms, these populations tend to be in API longer, further lowering the already limited capacity. There are a few assisted living facilities for these populations within the State, but as with API, capacity is an issue. Furthermore, patients at API are of a higher acuity and often hard to place.

Admissions and Discharges

Several stakeholders noted that the limited capacity is possibly causing API to discharge patients before they are fully stabilized, in an effort to maintain sufficient beds for persons awaiting treatment at API who are being held in hospital emergency departments (and sometimes jails) in outlying areas. While API is an acute psychiatric facility, premature discharges are potentially contributing to the high readmission rates seen at the facility. Correlated to the capacity issues API and Alaska as a whole face, are issues related to admissions and discharges.

- **Admissions:** Other than the noted feedback related to admissions during the weekend, the feedback PCG received related to admission processes was for the most part positive. Providers who have referred patients to the facility felt that API does an adequate job admitting patients, when capacity permits.
- **Discharges:** However, various stakeholders expressed concerns about discharge processes, specifically discharge planning. Perhaps due to the capacity challenges faced by API, multiple stakeholders indicated that patients were being discharged before they are fully stabilized. While some providers have addressed the problem by inserting full-time staff into API to assist with discharge planning, others are unable to do so. However, early discharges are believed to be related to high readmission rates at API, patients entering the criminal justice system, and homelessness. As previously noted, with minimal outpatient services and few housing options, discharge planning is critical to positive outcomes once a patient departs API.

4.0 LITERATURE REVIEW ON PRIVATIZATION

PCG performed an extensive review of the existing literature related to the privatization of state-operated psychiatric hospitals. Through this review PCG sought to identify the effects of privatization on financial performance and service delivery outcomes when operations were assumed by a private contractor. While there is little existing literature related to the privatization of state-owned psychiatric hospitals, there are ample studies on the effects of privatization for two other types of publically-administered facilities: prisons and general hospitals. While neither facility type provides a direct “apples to apples” comparison due to differences in services provided and populations served, there are various reasons applying “lessons learned” from the privatization of prisons and general hospitals to potential outcomes of psychiatric hospital privatization. As seen in states like Florida, the private correctional industry has begun to transition into the mental health market. Therefore, it is appropriate to use the existing literature on prison privatization as an indicator of likely organizational behavior for an incoming private operator, along with associated cost and service delivery outcomes. The examination of literature on general hospital privatization can also serve as a useful metric for assessing potential outcomes of privatization. While differing in the types of services offered and patients served by a psychiatric hospital, there are numerous similarities from which revenue generation strategies and service delivery implications can be gleaned. Absent more specific information on state-operated psychiatric hospital privatization outcomes, examining the effects of privatization on these two organizational types can serve as a useful estimation of likely outcomes caused by the shift from public to private operation. Where available, PCG has also noted observed differences related to the ownership type of a private provider, whether for-profit or not-for-profit.

4.1. Lessons from Prison Privatization

In recent decades, state and federal correctional agencies have increasingly outsourced the functions, responsibilities, and in some cases, capital assets of their prison systems to the private sector. The procurement of private correctional companies to operate prisons was seen initially as a mechanism to relieve pressure on prison capacity, while controlling escalating costs. Furthermore, privatization presented itself as a method to reduce the immense administrative burden associated with housing large populations for state and federal jurisdictions. Over the years, a large body of relevant literature has been accumulated to suggest the actual effects of prison privatization. PCG focused our analyses on two types of outcomes: cost and service delivery.

There are various reasons for thinking that a prison under private management would operate at a lower cost than public management. According to Austin and Coventry (2001), “the first and foremost argument in favor of privatizing prisons is that private managers will be more effective and efficient than public managers or prison facilities. It is argued that unlike state or federal governments, private firms are free (to some extent) from politics, cumbersome bureaucracies, and costly union contracts⁴”. Through a national survey funded by the Bureau of Justice Assistance and the U.S. Department of Justice, Austin and Coventry performed a comparison of private and public prisons to identify whether privatized prisons were in fact more cost-efficient. The findings suggest that only modest savings could be found through staffing reductions and lower employee benefit costs under a private operator. However, the savings found were substantially lower than projected; privatization led to a 1% savings compared to a 20% projected savings. In 1999, Pratt and Maahs performed a meta-analysis of 33 different cost effectiveness evaluations of public and private prisons to determine whether financial efficacy was improved under a private entity. They found “that private prisons were no more cost-effective than public prisons, and that other institutional characteristics - such as the facility’s economy of scale, age and security level - were the strongest predictors of a prison’s daily per diem cost⁵”. A 2009 meta-analysis conducted by researchers at the University of Utah revealed similar findings. The savings created through privatization “are not guaranteed and

⁴ Austin, J., & Coventry, G., (2001) “Emerging Issues on Privatized Prisons”, Bureau of Justice Assistance

⁵ Pratt, T., & Maahs, J., (1999) “Are Private Prisons More Cost-Effective Than Public Prisons?”, Crime and Delinquency

appear minimal.”⁶ Certain states have adopted cost savings requirements for an incoming private operator as a means to ensure cost savings through privatization. Hakim and Blackstone (2014) note that while these contractual requirements can be helpful in encouraging a reduction of costs under a private operator, they cannot conclusively prove that privatization yields cost savings. The authors suggest that various additional costs, such as capital expenditures, are not always included in the state’s measurement of current costs, which may inflate or deflate the calculated cost savings of privatization.⁷ Therefore, it is not possible to state empirically that cost-savings requirements actually produce the intended savings. However, Hakim and Blackstone did acknowledge that the presence of a private prison within a state’s larger correctional system did seem to lower costs at peer public facilities through increased market competition. In 2016, the Department of Justice (DOJ) announced that it would cease to use private prisons, citing among its reasons, unrealized cost savings.⁸ This announcement was contested by certain industry stakeholders who cited a lower per capita cost for inmates in privatized federal prisons. However, the majority of the existing literature indicates that in most cases, the privatization of state and federal prisons produced negligible savings.

Another reason cited by DOJ for the discontinuation of for-profit prison use at the federal level were the impacts on service delivery, and specifically lower quality outcomes for inmates. In earlier years, privatization was seen as a possible means to reduce overcrowding and improve service delivery under the assumption that private management would have the autonomy and agility to implement process changes that would improve inmate outcomes while reducing overall costs. However, the current literature does not definitively corroborate these assumptions. Overcrowding of prisons was a contributing factor to the proliferation of private prisons in the 1980s. Hakim and Blackstone found that private prisons did assist in relieving census pressure. The authors give the example of California, which was able to relieve census pressure by transferring inmates to out-of-state, for-profit prisons. However, due to decreasing incarceration rates, the number of federal inmates has been steadily decreasing. This contributed to DOJ’s announcement to end the use of for-profit prisons. In 2016, Deputy Attorney General Sally Q. Yates stated “private prisons served an important role during a difficult period, but time has shown that they compare poorly to our own bureau.” She continued to note that for-profit prisons generally provide fewer rehabilitative services that are “essential to reducing recidivism and improving public safety.” Duwe and Clark (2013) conducted a comparative analysis of recidivism rates for former inmates in state-run prisons and for-profit prisons in Minnesota. Their findings suggest “that private prisons are not more effective in reducing recidivism, which may be attributable to fewer visitations and rehabilitative programming opportunities for offenders incarcerated at private facilities.”⁹ Therefore, post-incarceration outcomes for former inmates appear to be worse if housed at a for-profit prison due to lower exposure to necessary services that promote healthy reintegration into society.

Further research examined differences in the quality of confinement between private and public prisons. Lundahl et al. (2009) found that the quality of confinement was slightly better at publicly managed prisons due to better rehabilitative services and skills training and lower inmate grievances. In 2016, the Federal Bureau of Prisons (BOP), which is the component of the DOJ responsible for all federal prisons, compared 14 contract (private) institutions to 14 bureau institutions. Their analysis examined eight component categories: contraband, reports of incidents, lockdowns, inmate discipline, telephone monitoring, selected grievances, urinalysis drug testing, and sexual misconduct. BOP’s analysis found that “with the exception of fewer incidents of positive drug tests and sexual misconduct, the contract prisons had more incidents per capita than the BOP institutions in all of the other categories of data we examined.”¹⁰ This finding suggests that security and safety incidents are higher at for-profit prisons than they are at federally-operated institutions. Coupled with higher recidivism rates and lower quality of

⁶ Lundahl, B., Kunz, C., Brownell, C., Harris, N., & Van Vleet, R., (2009) “Prison Privatization: A Meta-analysis of Cost and Quality of Confinement Indicators”, University of Utah

⁷ Hakim, S., & Blackstone, E., (2014) “Prison Break: A New Approach to Public Cost and Safety”, Independent Policy Report

⁸ Savage, C., (2016) “U.S. to Phase Out Use of Private Prisons for Federal Inmates”, New York Times

⁹ Duwe, G., Clark, V., (2013) “The Effects of Private Prison Confinement on Offender Recidivism”, Criminal Justice Review

¹⁰ Office of the Inspector General, (2016), “Review of the Federal Bureau of Prisons’ Monitoring of Contract Prisons”, U.S. Department of Justice

confinement, the literature suggests that privatization does not lead to improved service delivery or inmate outcomes.

PCG's findings from our literature review of prison privatization echo those released by DOJ. There is no clear evidence to suggest that transitioning management of state and federally-operated institutions to private management achieves substantial cost-savings or improved service delivery. In fact, the existing literature suggests that inmates at for-profit prisons are less likely to receive critical rehabilitative services, show higher rates of recidivism, and are incarcerated in less safe conditions. Additionally, the cost savings of privatization are negligible.

4.2. Lessons from General Hospital Privatization

PCG also reviewed existing literature on general hospital privatization. While differing in the types of services performed at psychiatric hospitals, an examination of general hospital privatization would provide insights on the areas in which the two facility types overlap as well as provide an understanding of the overall implications of privatization. Additionally, our analysis aimed to identify differences in general hospital organizational behavior based on ownership type, particularly examining nuances related to cost efficiency and service delivery outcomes between not-for-profit and for-profit hospitals. Much like in the previous section, PCG aimed to analyze the financial and quality outcomes of privatization at general hospitals.

Privatization of general hospitals is often seen as a way to lower costs by implementing certain efficiencies not available to a public entity. In 2005, the National Bureau of Economic Research (NBER) performed a meta-analysis of financial performance of for-profit, not-for profit- and government-owned general acute hospitals. The findings suggest "little differences in cost among all three types of hospital ownership, and that for-profit generate more revenue and greater profits than not-for-profit hospitals, although the difference is only of modest economic significance. There is little difference in revenue and profits between government and not-for-profit hospitals,"¹¹ A previous NBER study conducted in 1998 showed similar findings with no significant cost differences between the three ownership types¹². Therefore, while the cost of operations appears to be relatively comparable across the three hospital types, the 2005 study suggests that revenue generation differs among ownership type, with for-profit hospitals producing the most revenue and being the most profitable. This could potentially be accounted for by the type of services being delivered by each respective hospital type. Horwitz (2005) provides the following as a possible explanation: "For-profits are most likely to offer relatively profitable services: government hospitals are most likely to offer relatively unprofitable services; nonprofits often fall in the middle."¹³ This finding is supported by a 2013 study by Villa which found that after privatization, hospitals increased their operating margins. In order to increase margins, hospitals can either increase the amount of revenue they generate or reduce overall operating costs. Villa found that for-profit hospitals typically increase revenues by focusing on more profitable activities, while dropping unprofitable services. Cost savings are typically produced through a reduction in staff or lowering the facility's bed capacity.¹⁴ These findings suggest that privatization is not inherently more cost effective. Simply shifting to private management is not enough to generate savings, as for-profit, not-for-profit and public hospitals tend to show few cost differences. Rather, in order to generate cost savings, a private provider would have to increase revenue by prioritizing the more profitable services while discontinuing unprofitable activities. With this in mind, the impact of privatization on service delivery must be considered.

There are several sub-components to consider when assessing the impact of privatization on service delivery outcomes, including quality and access to care. PCG did not find any literature that conclusively determined a

¹¹ Shen, Y., Eggleston, K., Lau, J., Schmid, C., (2005) "Hospital Ownership and Financial Performance: A Quantitative Research Review", National Bureau of Economic Research

¹² Sloan, f., Picone, G., Taylor, D., Chou, S., (1998) "Hospital Ownership and Cost and Quality of Care: Is There a Dime's Worth of Difference?", National Bureau of Economic Research

¹³ Horwitz, J., (2005) "Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals", Health Tracking

¹⁴ Villa, S., (2013), "Assessing the Impact of Privatizing Public Hospitals in Three American States: Implications for Universal Health Coverage", Value in Health

difference in quality of care due to privatization or ownership type. The 1998 NBER study showed “trivial differences” in quality outcomes between the three different ownership types.¹² However, as previously stated, the types of services being provided differ depending on ownership type. Therefore, a true comparison of quality is difficult to assess given the varying service delivery systems among the hospital types. However, there is substantial literature indicating that privatization and/or ownership type can affect access to care. Norton and Staiger (1994) suggest ownership type affects the amount of uninsured patients taken on by a hospital. For-profit hospitals typically serve fewer un-insured patients.¹⁵ However, the authors do note that for-profit hospitals are often able to do so by selecting locations that do not have a high uninsured population. When examining the effects of privatization on access, it is important to acknowledge the ownership type of the incoming contractor. Desai et al. (2000) point out that “once a hospital decides to privatize, it can convert to either for-profit or non-profit status. Several empirical studies suggest that, on average, non-profit hospitals provide much more uncompensated care than for-profits do.”¹⁶ Desai continues to point out that public hospitals are also more likely to provide unprofitable but necessary services such as emergency room care. Privatization, however, does not only impact the uninsured in terms of accessibility. As previously mentioned, as a means to increase revenue and operating margins, for-profit hospitals often discontinue the provision of unprofitable services. Thorpe et al. (2000) note that previous hospital privatizations have largely occurred in rural areas, further exacerbating access issues.¹⁷ While privatization can deter access to the uninsured, insured individuals needing services that have been deemed unprofitable by a for-profit provider can also experience difficulties in receiving needed medical care. Rundall and Lambert (1984) noted that upon the transition from state management to private management, hospitals commonly saw a reduction in services that were not profitable, such as outpatient psychiatric services. The authors provide the following explanation: “The public sector traditionally has provided the public goods viewed as unprofitable by the private sector...It is the task of public health policymakers to reconcile cost-control and efficiency mechanisms brought about by private management with the community's right of access to comprehensive medical care.”¹⁸

PCG found no clear evidence to indicate that privatization of general hospitals is inherently beneficial from a cost or service delivery perspective. Costs between state-managed and privately-managed general hospitals tend to fall in a comparable range. However, as noted above, there are means by which a private contractor can increase revenue by restructuring service delivery to prioritize more profitable services, reducing uncompensated care, and lowering bed counts. However, these methods are largely contingent on numerous factors and may not be applicable to all hospitals, including state-operated psychiatric hospitals, and often come at the expense of patient access. The elimination of unprofitable services would require a hospital to be within a larger system capable of absorbing the impact. A reduction in uncompensated care would only be feasible with an alternate safety net provider within the area. Reductions in available beds would also assume an adequate level of system capacity. Therefore, while there are some benefits to privatization of a general hospital, there are numerous extraneous variables to consider when applying these findings to a state-operated psychiatric hospital.

¹⁵ Norton, E., & Staiger, D., (1994) “How Hospital Ownership Affects Access to Care for the Uninsured”, The RAND Journal of Economics

¹⁶ Desai, K., Van Deusen, C., Young, G., (2000) “Public Hospitals: Privatization and Uncompensated Care”, Health Affairs

¹⁷ Thorpe, K., Florence, C., Selber, E., (2000) “Hospital Conversions, Margins and the Provision of Uncompensated Care”, Health Affairs

¹⁸ Rundall, T., & Lambert, W., (1984) “The Private Management of Public Hospitals”, Health Services Research

5.0. NATIONAL PRIVATIZATION EFFORTS

This section offers profiles of other privatization efforts initiated across the country in order to highlight lessons learned from successful privatization initiatives as well as bids that failed to be implemented.



FLORIDA

Type: Full Privatization of State Hospitals

Year: 1998-2003

Reason: As a result of the inefficiencies in meeting population health needs, South Florida State hospital was facing a class-action lawsuit concerning quality of patient care. In the bid to resolve the issue, GEO Group took over South Florida State Hospital in 1998, making it the first privately owned psychiatric facility in the U.S at a time when sexual abuse and patient deaths due to violence and neglect were an everyday sight.

Outcomes: The GEO Care-controlled hospital reached some significant operational milestones, such as restoring accreditation for the facility, eliminating waiting lists for patient admissions by reducing the average patient stay, and nearly eliminating the use of seclusion and restraints to manage patient behavior. Noting these improvements, a resolution was passed in 2003 supporting further privatization of Florida's psychiatric facilities which included the South Florida Evaluation and Treatment Center, Treasure Coast Forensic Treatment Center and West Florida Community Care Center. The state's Department of Children and Families also reported notable cost savings in Florida's privately operated facilities where cost per bed was 15% lower than state-run facilities.

Lessons for Alaska: Privatization efforts in Florida, which resulted in not only lowering costs but also improved the quality of patient care at the facilities, has become a paradigm case for state hospital privatization.



PENNSYLVANIA

Type: Privatization of forensic hospital care

Year: 2007-2008

Reason: Following Florida's lead, the state Public Welfare Department in Pennsylvania also considered privatizing and merging its state mental hospital units, hoping that it would reduce state costs and improve quality of care.

Outcomes: The department issued RFPs to examine constructing privately run forensic facilities at Torrance State Hospital and Norristown Hospital. However, the department withdrew its RFP after reaching a cost-saving agreement with union leaders which proved to be immensely efficient in maintaining sustained employment and standard of care at the facilities. In fact, it was projected that this agreement would also save the state more money than privatization would have, estimating savings to be \$1.5 million the first year.

Lessons for Alaska: Other options of cutting costs should be considered similar to the cost-savings agreement with union leaders in Pennsylvania which not only proved to be cost efficient but also helped maintain employment and improve quality of patient care.

**WISCONSIN****Type:** Privatization of County Psychiatric Hospital**Year:** 2015-Present

Reason: Milwaukee County Mental Health Board, a board of behavioral health experts, last year, voted on privatizing the operations of Milwaukee's mental hospital in order to reduce costs and foster efficiency of service.

Outcomes: The Behavioral Health Division issued an RFP to contract the hospital's in-patient services, emergency room and observation unit. Additionally, the RFP also requested that a new upgraded facility should be built. The RFP received two bids but administrators of the BHD delayed the process to utilize more time to consider other options. Hence, the decision to privatize Milwaukee's mental hospital is still underway until the best solution is crafted to address the problems of the current facilities at the hospital.

Lessons for Alaska: All factors and other alternatives should be considered to make sure that private vendors have the capacity to run the facility more efficiently than the State.

**KANSAS****Type:** Full Privatization of State Hospitals**Year:** 2016-Present

Reason: Kansas Department of Aging and Disability Services is currently considering privatization of two of its troubled state-run mental hospitals, Osawatomie and Larned. In addition to dealing with staffing shortfalls and deteriorating quality of patient care at both facilities, Osawatomie lost its Medicare certification and is undergoing \$1 million each month in federal payments.

Outcomes: The agency decided not to privatize Larned State Hospital in western Kansas but is considering privatization of Osawatomie. While efforts have been initiated towards getting Medicare recertification for Osawatomie, privatization appears to be an ideal option in improving other operations at the facility. This idea is heavily criticized by individuals who fear that just like other accounts of privatization in the country, privatization of Osawatomie will deteriorate the standard of patient care at the facility and will culminate in bringing an increment in costs. However, just recently a request for proposals to operate Osawatomie State Hospital was posted which is seeking private contractors to operate the hospital, permitting the contractor to shift more than half of the hospital's beds to other parts of eastern Kansas. This proposal has not yet been approved by the legislature and was only issued by KDADS to explore its options.

Lessons for Alaska: Even with the loss of accreditation due to the state's management of the hospital, there is opposition to privatization in Kansas due to public concerns which have triggered political controversies over privatizing state functions.

**GEORGIA****Type:** Privatization of forensic hospital care**Year:** 2008-2009

Reason: Like many other states, Georgia battled budget cuts and escalating costs to maintain its mental health facilities. In addition to the budget crisis, the U.S Justice Department revealed the amount of neglect in the quality of patient care in the state-run facilities and reported cases of patient abuse and death. To prevent a lawsuit, an

initiative was taken by Georgia's department of Human Resources to privatize all state-owned and operated mental services in 2008, with the aim of improving service quality and minimizing costs.

Outcomes: The initiative involved closing all seven of its existing state hospital and building three privately financed and operated facilities. Two RFPs were issued: one for privatizing and merging forensic mental health services in all seven facilities to Milledgeville and the other to privatize and build new psychiatric hospitals in Atlanta and South Georgia. However, state lawmakers were skeptical of the privatization plans, arguing whether it would actually improve patient care quality or help lower costs. Considering failed attempts of privatization in other states, Georgia decided not to privatize its state-run facilities.

Lessons for Alaska: Georgia decided not to privatize following the failed outcomes of privatization in other states. States that did consider privatization were not able to achieve their intended results, for example in the case of North Carolina where an audit found that the state wasted \$400 million by allowing unqualified private firms to provide mental health services.



TEXAS

Type: Privatization of forensic hospital care

Year: 2011-2012

Reason: GEO Care opened the only privately operated, state-funded mental health hospital, Montgomery County Mental Health Treatment Facility in Texas in 2011, anticipating it would lower costs.

Outcomes: The 100-bed facility provides forensic psychiatric services treating individuals that have been committed by the court, are incompetent to stand trial, and are guilty by reason of insanity. The facility brought 175 jobs to Conroe and has been reported to run at a cost 31% cheaper than other State facilities. However, the facility was fined for violations of patient care standards which resulted in putting other ongoing privatization efforts in doubt.

Lesson for Alaska: Privatization of Montgomery County Mental Health Treatment Facility in Texas helped reduce operating cost and increase employment but at the cost of patient care standards.



TEXAS

Type: Full Privatization of State Hospitals

Year: 2012-2014

Reason: Among other hospitals that were considered for privatization in the state of Texas were Kerrville State and Terrell State. The pursuit of privatization of the government-owned Terrell State Hospital was prompted by the 2012 death of a 62-year old patient at the facility.

Outcomes: Kerrville State had received a bid from Geo Care in 2012 which was turned down when State Health Services evaluated that it was too risky to lower the budget by 10% to run the hospital which would result in lower staffing levels that would eventually compromise patient care. Furthermore, at Terrell State Hospital, the investigation that followed revealed quality of care problems which were causing immediate threat to patient well-being and safety. In fact, the Centers for Medicare and Medicaid Services threatened to pull \$5 million in federal funding from the hospital to force immediate action to improve patient care, and the state even considered closing Terrell's medical unit for patient safety. In October 2014, state officials announced that they had awarded a five-year contract to run the hospital to Correct Care Solutions, a Nashville-based correctional and psychiatric healthcare which absorbed Geo Care. Terrell State hospital was in the final process of closing the deal until

recently when a state audit exposed that Geo Care was bypassing procurement laws and was not working in the most economical manner that would benefit the state. Hence, the deal was called off.

Lessons for Alaska: Terrell State Hospital's case illustrates the procurement irregularities and lack of transparency in the contracting process that often accompany privatization efforts in other states.



NEW HAMPSHIRE

Type: Contracting Psychiatry and Advanced-Level Nurses

Year: 1988-Present

Reason: New Hampshire recently battled a class action lawsuit over inadequate mental health services and the state continues to spend tens of millions of tax dollars to improve care. New Hampshire Hospital is the only public psychiatric hospital in the state, and while most of its staff is overseen by the state, 19 psychiatrists, advanced-level nurses and administrators are contracted out to Dartmouth College's Geisel School of Medicine. Dartmouth College ended its contract with the hospital when the lease was slated for renewal, leaving Dartmouth-Hitchcock as the only bidder to take over.

Outcomes: The staff was unhappy with the contract presented by Dartmouth-Hitchcock and rejected it to form their own practice group. The Department of Health and Human Services has made a proposal to extend their existing contract with Dartmouth College which gives the state some time to decide whether to accept Dartmouth-Hitchcock's proposal or open the bid process again. However, this lag has resulted in staffing shortfalls at the facility which is putting the already fragile mental health system further at risk.

Lessons for Alaska: The case in New Hampshire shows that workforce is sensitive to change in compensation which could result in staffing shortfalls.



INDIANA

Type: Full Privatization of State Hospitals

Year: 2005-2006

Reason: The idea of privatizing the operations of state-run mental hospitals in Indiana was first proposed in 2005 with the aim of improving and delivering a higher level of care.

Outcomes: Plans were made to privatize three mental state hospitals in Madison, Richmond and Evansville with the objective of having privatized at least one of them by 2006. However, this idea was met with criticism as there was uncertainty that privatization would improve quality of care. Instead, it was argued that it would ultimately increase the already large influx of patient admissions which would in fact worsen the quality of patient care. Progress was made at the Richmond hospital where a bid was submitted to run the facility. However, the plan was terminated when it was realized that it would cost more money to the taxpayers to have the facility run by a private entity than it would for the state to run it. And while privatization plans called for corporations to be in control of state hospitals in Madison and Evansville, no bids were received.

Lessons for Alaska: While privatization in Florida resulted in lowering costs and improving quality of care, this may not always be the case.

**KENTUCKY****Type:** Contracting Hospital Nursing Staff**Year:** 2000-2008

Reason: Kentucky decided to contract most of its nursing staff due to the long and time-consuming nature of the hiring process which caused difficulty filling vacant positions quickly to meet patient needs.

Outcomes: Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracts with private companies and Community Mental Health Centers (CMHC) to hire most of its nursing staff. In fact, Kentucky appears to be using contracted nursing staff more extensively than other surrounding states with the highest percentage of nursing staff at 65%. Contracting nursing staff helped narrow the gap of demand and supply of nurses to meet patient needs. However, the state had to pay millions in administration expenditures to these private companies in addition to the salaries paid to contract nursing staff. There was also a lack of oversight and monitoring in contracting the nursing staff, which has resulted in significantly higher numbers of contract employees than state employees.

Lessons for Alaska: The State should consider privatizing service segments like nursing staff or certain functions like management or operations to maintain high standards of patient care but should also limit the use of contract employees to be more cost effective and sustain a stable workforce. Kentucky's case also illustrates how lax contract monitoring standards led to inappropriately high numbers of contract employees and reports of waste from the State's Office of the Inspector General. Furthermore, Kentucky had to face consequences when a private entity that provided nursing staff to Central State Hospital went bankrupt.

**UTAH****Type:** Privatization of forensic hospital care**Year:** 2009-2011

Reason: Due to the state's budget situation, Utah decided to consider options to privatize certain units within USH and USDC to be operated at a lower cost and provide expanded care at a higher level of service.

Outcomes: PCG conducted a feasibility study to determine whether units in these facilities could be operated by a private entity for the same or less cost, at the same or higher level of service. The study found that it is possible for the current level of services provided at the facilities to be provided for the same cost in a privatized scenario. In fact, the study showed that private firms could provide expanded care to patients at the facility for a cost savings. However, these savings would come from a reduction in staff compensation which could lead to staff turnover that could potentially cause an adverse impact to the quality of care for patients. Hence it was recommended that Utah should not pursue the option of privatizing as it could compromise quality of patient care by doing so.

Lessons for Alaska: It is possible to reduce costs through privatization but risks should be considered as these savings may come at a price, which in Utah's case was determined to be a potentially negative effect on the quality of services and continuity of care for the patients.

**NORTH CAROLINA**

Type: Privatization of forensic hospital care

Year: 2006-2008

Reason: The Department of Health and Human Services issued an RFP for the consolidation of forensic hospital care to save money due to the budget crisis the state was facing.

Outcomes: GEO Care was the sole respondent to the RFP. However, it was realized that cost savings over the long term seem unlikely, and if achieved, will most likely come at the expense of quality of care and services to patients. There was a lot of skepticism and opposition from the North Carolina Psychological Association who believed that GEO care or any other vendor will not be able to achieve cost savings while ensuring safety and quality of care. Furthermore, if the privatization initiative failed, costs to re-establish a state-run service would likely be significant hence the RFP was cancelled.

Lessons for Alaska: North Carolina's situation was very similar to Utah and Georgia. Privatization did not seem feasible as cutting costs would likely compromise the quality of patient care.

**MISSOURI**

Type: Privatize acute psychiatric inpatient and emergency services

Year: 2006-2011

Reason: From 2006 through 2011, Missouri Department of Mental Health transferred its acute inpatient and emergency services to Truman Medical Center due to the state's budget crisis.

Outcome: Initially, DMH did not make its intent to privatize these acute care and emergency service operations transparent. It issued an RFP for private entities to lease out the department's acute care and emergency services in 2009. There were only two respondents to the RFP and in 2009, Truman Medical Center formally assumed the acute inpatient services through a lease agreement with the State, making Missouri one of the only states to privatize its acute care services. Truman operated 50 adult acute care beds and 12 ED beds at Center for Behavioral Medicine until recently when it closed down the emergency department in 2015.

Lessons for Alaska: DMH did not do due diligence to create market competition to achieve the results it was supposed to by privatizing its acute care and emergency services. The fact that TMC closed down the emergency department shortly after transfer also presents evidence of the risks of privatizing expensive, unprofitable acute services.

6.0. BASELINE ANALYSIS

6.1. Purpose of the Baselines

In order to create predictive models and fully identify areas for cost savings, PCG determined a cost baseline for financial operations at API as well as a baseline for comparing its service delivery characteristics with other hospital systems. Doing so has afforded PCG with a clearer understanding of the current mechanisms driving costs and allowed us to recognize current revenue streams and identify areas for savings. However, due to the geographic and demographic uniqueness of any facility based in Alaska, it is important to contextualize findings by comparing them to other states and state-run psychiatric hospitals. This section summarizes the findings of PCG's baseline analysis.

PCG's method for determining API's financial baseline focused on the following tasks: examining cost trends for the last five years at API, benchmarking API's costs to national reported costs, comparing costs to a cohort of peer facilities, and examining the distribution of revenue by payer source. To do so, PCG used data from the following sources:

- Alaska Mental Health National Outcome Measures (NOMS)
- National Association of State Mental Health Program Directors (NASMHPD) Research Institute
- CMS 2552 Hospital Cost Reports

The service delivery baseline model for API assesses the current state of API and then analyzes how the current state compares to their performance over time, national averages and to other identified peer hospitals. To evaluate the service delivery baseline at API, PCG analyzed utilization, admissions, average length of stay (ALOS), discharges, readmissions, staffing, and the diagnostic profile of its service population. In conducting these analyses, we were able to better understand the role of API in Alaska's behavioral health and medical care systems, as well as assess the factors that would affect the quality of care in various privatization options.

6.2. API Cost Trends

The crucial step in creating PCG's baseline financial model was to look at the main cost drivers at API over the past five years. PCG examined CMS cost report data for fiscal years 2011 through 2015, the latest year available. PCG's rationale for this approach was two-fold: costs could be analyzed as they appear on API's trial balance, and salary and other costs could be discretely broken out. This approach has allowed PCG to target the specific cost centers that have increased throughout the past five years, and to gain a better understanding of the extent to which expenditures have been driven by personnel versus non-personnel costs. Table 6.2.1 provides a brief overview of cost trends at API:

Table 6.2.1: API Salary and Other¹⁹ Costs, FY11- FY15

Cost Center	FY11	FY12	FY13	FY14	FY15	5 Year Variance
Salary	\$16,012,083	\$15,224,839	\$16,103,927	\$16,279,285	\$17,509,916	9%
Other	\$15,687,994	\$16,467,540	\$15,067,973	\$14,481,616	\$15,188,872	-3%
Total	\$31,700,077	\$31,692,380	\$31,171,900	\$30,760,901	\$32,698,789	3%

¹⁹ Includes all non-salary expenses including: benefits, purchased services, commodities, contracts, capital costs

As illustrated above, total costs at API have increased by 3% from FY11 to FY15. This increase has been driven primarily by salary costs which increased by 9% over the five years, while other costs decreased by 3% over the same period. This suggests that staffing related expenditures are largely responsible for the increase in total operating costs at the hospital. This was an important finding of the preliminary analysis as it helps further contextualize historic cost increases at API. Since, it is assumed that a private contractor would make efforts to contain all costs where possible, these findings indicate that employee salary costs are a possible avenue of doing so. PCG analysis then focused on specific cost center trends. PCG identified the top five cost centers that are driving total costs at API. Collectively, these centers represent 86% of API's total annual costs. The table below shows the amounts reported for each cost center.

Table 6.2.2: Top Five Total Cost Drivers at API, FY11-FY15

Cost Center	FY11	FY12	FY13	FY14	FY15	5 Year Variance
Direct Care	\$13,872,282	\$13,164,515	\$12,219,446	\$11,609,901	\$12,584,248	-9%
Employee Benefits	\$8,185,624	\$8,470,520	\$8,989,919	\$9,221,910	\$9,724,088	19%
Administration & General	\$3,006,357	\$3,262,826	\$2,807,867	\$3,231,344	\$3,200,623	6%
Operation of Plant	\$1,347,579	\$1,602,874	\$1,519,452	\$1,334,678	\$1,363,061	1%
Dietary	\$1,156,832	\$987,667	\$933,425	\$963,247	\$1,089,506	-6%
Percentage of Total Costs	87%	87%	85%	86%	86%	-1%

By examining five year trends in total costs, PCG identified areas for further analyses. For example, PCG could not identify whether the 9% decrease shown above in total Direct Care costs was due to decreases in salary or other direct care costs. PCG performed similar analyses for both salary and other costs which are summarized in the two tables below.

Table 6.2.3: Top Five Salary²⁰ Cost Drivers at API, FY11-FY15

Cost Center	FY11	FY12	FY13	FY14	FY15	5 Year Variance
Direct Care	\$10,939,634	\$9,945,348	\$10,931,947	\$10,473,165	\$11,471,603	5%
Administration & General	\$1,626,780	\$1,672,342	\$1,636,941	\$1,748,157	\$1,654,550	2%
Social Services	\$737,686	\$906,178	\$660,463	\$801,468	\$746,400	1%
Nursing Administration	\$746,219	\$670,883	\$617,514	\$733,226	\$967,253	30%
Operation of Plant	\$555,778	\$552,945	\$589,734	\$575,193	\$591,849	6%
Percentage of Total Salary Costs	91%	90%	90%	88%	88%	-3%

²⁰ Does not include costs related to employee benefits

Table 6.2.4: Top Five Other²¹ Cost Drivers at API, FY11-FY15

Cost Center	FY11	FY12	FY13	FY14	FY15	5 Year Variance
Employee Benefits	\$8,185,624	\$8,470,521	\$8,989,919	\$9,221,910	\$9,724,088	19%
Direct Care	\$2,932,648	\$3,219,168	\$1,287,500	\$1,136,736	\$1,112,645	-62%
Administration & General	\$1,379,577	\$1,590,484	\$1,170,927	\$1,483,188	\$1,546,073	12%
Dietary	\$1,156,833	\$987,667	\$933,425	\$963,248	1,089,506	-6%
Operation of Plant	\$791,801	1,049,929	\$929,719	\$759,485	\$771,212	-3%
Percentage of Total Other Costs	93%	88%	94%	94%	94%	1%

The top five cost centers account for nearly 89% of salary costs (Table 6.2.3) and 92% of other costs (Table 6.2.4) respectively. Among these two groups, there are three common cost centers: Direct Care, Administration & General, and Operation of Plant. Historically, these three centers alone have accounted for 54% of API's total expenditures. The following subsection provides a more in-depth explanation of the major cost centers, as well as highlights noteworthy variances in the smaller cost centers.

Direct Care²²: From FY11-FY15, Direct Care saw a decrease of 9% in total costs. While, salary costs increased by 5%, the aggregate decrease was caused by the 62% decrease in other costs.

Administration & General: From FY11-FY15, Administration and General Total costs increased by 6%. While salary costs only increased by 2%, other costs increased by 12%.

Operation of Plant: Total facility operation costs remained relatively steady with only a 1% increase over the five-year period.

Employee Benefits: API's benefit costs have steadily increased each year, with an aggregate increase of 19% over the five-year period.

Nursing Administration: From FY11-15, Nursing Administration increased by 28% in total costs from \$756,471 to \$969,494. This increase was primarily driven by salary expenditures which increased by 30% from \$746,219 to \$967,253 over the five year period.

Electronic Medical Records: The Electronic Medical Record (EMR) cost center represents the costs of operating the electronic medical records department at API. Total costs reported in the Medical Records cost center have nearly doubled in the past five years. Upon closer examination, while both salary and other costs have increased, the main driver appears to be other costs which increased by 485% from FY11-FY15. The cost reports show that in FY13 medical record costs jumped from a rough average of \$30,000 in prior years to \$1,012,710. Following FY13, the other costs associated with this center average to nearly \$194,000. These costs represent expenditures related to maintain the current EMR. In the stakeholder interviews, PCG was informed that necessary system upgrades are likely to further increase costs in this center.

Non-Reimbursable (Telehealth): Upon closer review of API's trial balance, PCG identified costs reported in the non-reimbursable section as costs related to providing telehealth services. Overall, these costs have increased by 278% over the past five years. Most notably, salary costs for telehealth services increased by 746% from \$42,534 in FY11 to \$360,030 in FY15.

²¹ Includes all non-salary expenses including: benefits, purchased services, commodities, contracts, capital costs

²² Classified under "Adults and Pediatrics" on CMS 2552 Medicare Cost Reports

Over the five-year period of FY11 to FY15, API's total costs have risen by approximately three percent. This increase has largely been driven by increases in salary costs. As noted in the stakeholder interviews by multiple parties, labor pool shortages in Alaska, and Anchorage specifically, have created an environment of competition between API, other state agencies, and private providers. The noted increase in the salary scale is reflected in PCG's findings and represents the need for increased compensation in order to recruit and retain necessary personnel. Related to compensation, employee benefits have increased significantly by 19% in the past five years. Understanding these variables was crucial in PCG's development of comparative models and privatization scenarios. Paired with stakeholder comment, the findings of this preliminary analysis identified areas of increasing costs and served as a basis in modeling a privatized API.

6.3. National Cost Trends

Before comparing API to our selected peer facilities, PCG determined it was necessary to gauge costs in Alaska relative to the United States as a whole. Doing so would help contextualize the findings for our planned analyses.

To compare Alaska to national benchmarks, PCG utilized publicly available data on state-run psychiatric hospitals from SAMHSA, including the Alaska 2014 Mental Health National Outcome Measures (NOMS), and data from the NASMHPD Research Institute (NRI). Since API is the only state-run psychiatric facility in Alaska, the data allows for a direct comparison of API's costs relative to national averages. NRI calculates cost per patient day, by dividing a state's total expenditures for state-run psychiatric facilities by total patient days. As a precautionary measure, data for cost per patient day was substantiated by comparing the data provided by NRI to API's cost reports for the given year. The following illustrates cost per patient day at API compared to the average of the United States.

Table 6.3.1: Cost Per Patient Day in Alaska and US Average, FY13

	Cost Per Patient Day
Alaska (API), FY 2013	\$1,447.30
United States Average, FY 2013	\$689.69

As illustrated above, the cost of providing services per patient day at API is twice as much as the national average. Various factors are contributing to this substantial difference. Due to Alaska's location, there is a lower availability of necessary providers, which drives salary and benefit costs to attract and retain skilled providers. Secondly, API only provides acute psychiatric care, which is more expensive than the sub-acute, long term care provided by many state-run psychiatric hospitals in other states. Therefore, in order to create a truly representative comparison, cost per individual patient should also be assessed. The following table illustrates the differences in cost per patient in Alaska compared to the continental United States.

Table 6.3.2: Cost Per Patient in Alaska and US Average, FY13

	Cost Per Patient	Difference
Alaska (API)	\$25,709	-57%
United States Average	\$59,275	-

As seen above, the cost per individual patient in Alaska, or more specifically at API, is less than half the national average. While this may seem counter-intuitive at first glance, given the wide gap between costs per patient day (Table 6.3.1), it can be explained at least partially by API's role as an exclusively acute care facility, as well as by

²³ NRI Table 17: SMHA Mental Health Controlled Expenditures Per Inpatient Day, All Patients In State Psychiatric Hospital Mental Health Services By State, FY13, NOMS 2013

the lack of sub-acute care within the state. API tends to serve a larger proportion of Alaska's seriously mentally ill population than other state hospitals. In other states, most public psychiatric hospitals are able to spread their costs across a wider broader of patients with varying levels of acuity.

When considered in combination with the hospital's admission rate and average length of stay (ALOS), it is apparent that API serves a significantly higher volume of individuals than similar hospitals in other states. Therefore, while the cost per day of care is much higher, the duration of care is much shorter and spread over many more individual patients, explaining the high variance in cost per patient.

6.4. Peer Cost Comparisons

With an understanding of the main cost drivers at API, and the cost of providing services relative to national benchmarks, PCG performed comparative analyses with ten peer state-run psychiatric facilities. These hospitals and their bed count, peer group (i.e., small or large), state, and ownership are provided in the table below:

Table 6.4.1: Selected Peer Hospitals

Peer Hospitals	Beds	Group	State	Provider
Alaska Psychiatric Institute	80	Small	AK	State
Anoka Regional Treatment Center	136	Small	MN	State
Arizona State Hospital	299	Large	AZ	State
East Louisiana State Hospital	470	Large	LA	State
Florida State Hospital	1230	Large	FL	State
Fulton State Hospital	354	Large	MO	State
South Florida State Hospital	350	Large	FL	Private
Southern Virginia Mental Health Institute	96	Small	VA	State
St. Elizabeth's Hospital	292	Large	DC	State
Taunton State Hospital	45	Small	MA	State
Wyoming State Hospital	75	Small	WY	State

Given Alaska's demographic uniqueness and API's status as the state's only state-run psychiatric facility, no single peer facility offers a perfect comparison. Therefore, PCG opted to identify multiple cohorts composed of hospitals of varying sizes and service units in order to guide our inferences. Various factors such as operating a forensic unit or similar bed size contributed to a hospital being chosen as a peer.

In order to perform comparative cost analyses, PCG obtained CMS-2552 cost reports for all the listed facilities. Cost reports were pulled for FY14, the most recent year of complete data on the Healthcare Cost Report Information Service (HCRIS). Since different hospitals use different accounting systems and software, PCG examined costs after reclassifications and adjustments. This provided PCG with a more standardized dataset for analysis.

Cost Per Patient Day: API and Peer Hospitals

While the most recent data available comparing Alaska's state hospital expenditures to national averages was dated back to FY13, more recent data was available to perform the comparative analysis with peer hospitals. Using HCRIS to pull FY14 cost report data, the latest available year at the time of this analysis, PCG compared cost per patient day at API and the selected peer facilities. In line with the comparison of Alaska's cost per patient day to the national average, costs were higher at API. The FY14 average for the entire peer group was \$754.68, roughly half of API's \$1521.71 per day. However, when compared to only the small peer group, the costs become

more similar, especially when compared to Taunton State Hospital in Massachusetts and Wyoming State Hospital. Upon closer examination, there are several considerations to note. While the larger facilities offer sub-acute long term care, most of the small facilities, with the exception of Southern Virginia Mental Health Institute, only offer services in the acute care setting. This is important to note as the average cost per patient day at the small facilities is significantly higher than the large peer groups. For the small peer group, the cost per patient day more closely resembles API's cost per patient day as service delivery is more comparable. Patients at small acute facilities receive much more intensive care, albeit for a shorter duration of time than in the larger peer facilities. Since this short-term acute inpatient care is far more resource intensive, the cost per patient day is significantly higher than facilities that provide long-term care. PCG's Baseline Service Delivery Model shows that in FY14 the ALOS for the small peer group was 188.31 days, compared to API's ALOS of 13.14. This suggests that at API patients are receiving much more intensive care for a shorter duration, which is supported by our previous analysis of cost per patient in Alaska versus the United States. The following table summarizes the previously discussed findings.

Table 6.4.2: Cost per Patient Day at API and Peer Facilities, FY14²⁴

Hospital	Size Cohort	Cost Per Patient Day
Alaska Psychiatric Institute	Small	\$1,521.71
Anoka-Metro Regional Treatment Ctr.	Small	\$979.51
Southern Virginia Mental Health Inst	Small	\$532.82
Taunton State Hospital	Small	\$1,325.61
Wyoming State Hospital	Small	\$1,315.84
Small Facility Peer Group Average		\$1,038.44
Arizona State Hospital	Large	\$707.42
East Louisiana State Hospital	Large	\$460.82
Florida State Hospital	Large	\$354.61
Fulton State Hospital	Large	\$703.99
South Florida State Hospital	Large	\$250.21
St. Elizabeth's Hospital	Large	\$915.99
Large Facility Peer Group Average		\$565.51

Cost Per Bed: API and Peer Hospitals

PCG also compared cost per bed for API and the selected peer facilities by dividing total costs by the number of beds. Similar to the comparison of cost per patient day, there was a wide variance between the peer groups of small facilities and large facilities, with average cost per bed being nearly double in the small facilities. Again, facilities that offer non-acute inpatient care show much lower costs per bed overall. As illustrated in the table below, while API's cost per bed was higher than the small peer group average, it was not the highest among the smaller facilities. This suggests that while overall expenditures per bed are high, they are not completely out of line with costs at similar facilities.

²⁴ FY14 CMS 2552 Cost Reports, Worksheet B, Part-I

Table 6.4.3 Cost per Bed at API and Peer Facilities, FY14²⁵

Hospital	Size Cohort	Bed Count	Cost Per Bed
Alaska Psychiatric Institute	Small	80	\$401,504
Anoka-Metro Regional Treatment Ctr.	Small	136	\$349,332
Southern Virginia Mental Health Inst	Small	96	\$132,683
Taunton State Hospital	Small	45	\$462,695
Wyoming State Hospital	Small	75	\$438,367
Small Facility Peer Group Average			\$356,916
Arizona State Hospital	Large	299	\$209,527
East Louisiana State Hospital	Large	599	\$156,005
Florida State Hospital	Large	1230	\$97,957
Fulton State Hospital	Large	354	\$248,491
South Florida State Hospital	Large	350	\$84,453
St. Elizabeth's Hospital	Large	292	\$301,553
Large Facility Peer Group Average			\$182,998

Cost Per FTE: API and Peer Hospitals

As noted in the analysis of cost trends at API, salary and benefit costs have consistently been a driving factor in overall costs at API for the past five years. Therefore, it is useful to understand how API compares to its selected peers in terms of compensation. As a preliminary analysis, PCG calculated salary costs per full-time equivalent (FTE) employee. Compared to the entire peer group average of \$67,941, API pays slightly higher in salary per FTE. However, as shown below, salary costs per FTE at API are roughly 16% lower than the small peer hospitals, and 5% higher than the large peer hospitals.

Table 6.4.4: Salary Cost per FTE at API and Peer Facilities, FY14²⁶

Hospital	Size Cohort	Total FTEs	Cost Per FTE
Alaska Psychiatric Institute	Small	230	\$70,779
Anoka-Metro Regional Treatment Ctr.	Small	393	\$92,122
Southern Virginia Mental Health Inst	Small	98	\$78,550
Taunton State Hospital	Small	175	\$60,537
Small Facility Peer Group Average			\$77,070
Arizona State Hospital	Large	374	\$80,118
East Louisiana State Hospital	Large	961	\$51,388
Florida State Hospital	Large	1007	\$54,486
Fulton State Hospital	Large	1269	\$35,933
South Florida State Hospital	Large	294	\$63,471
St. Elizabeth's Hospital	Large	600	\$94,867
Large Facility Peer Group Average			\$63,377

²⁵ FY14 CMS 2552 Cost Reports, Worksheet S-3 Part I, Worksheet B, Part I

²⁶ Data Source: FY14 CMS 2552 Cost Reports, Worksheet A, Worksheet S-3 Part I. FTE counts were unavailable from the Wyoming State Hospital cost reports.

Given the findings of our previous analyses and what is known about the labor environment in Alaska, it would be expected that API would be paying substantially more per FTE. However, salary is just a component of total compensation, and does not reflect the costs of employee benefits. Therefore, PCG estimated total compensation per FTE. To do so PCG divided each hospital's total salary costs by FTE, and reported benefits costs by FTE. While performing the analysis, PCG noticed that not all peer facilities break out employee benefits as a separate cost center. This suggests that the amounts in the table above, particularly for the smaller facilities, could potentially be inclusive of benefit costs. Unfortunately, without access to the trial balances for each facility not reporting employee benefit costs, any estimate of employee benefits would be purely speculative. However, it could explain why the hospitals are showing higher salary cost per FTE in comparison to API. PCG analyzed total compensation for the hospitals that broke out employee benefit costs. The findings are presented in the table below:

Table 6.4.5: Total Compensation per FTE at API and Peer Facilities, FY14²⁷

Hospital	FTE	Salary Cost Per FTE	Benefit Cost Per FTE	Total Compensation	Benefits as % of FTE
St. Elizabeth's Hospital	600	\$94,867	\$22,403	\$117,270	19%
Arizona State Hospital	374	\$80,118	\$30,982	\$111,100	28%
Alaska Psychiatric Institute	230	\$70,779	\$40,095	\$110,874	36%
South Florida State Hospital	294	\$63,471	\$15,268	\$78,739	19%
Florida State Hospital	1007	\$54,486	\$23,604	\$78,089	30%
East Louisiana State Hospital	961	\$51,388	\$23,525	\$74,913	31%

When averaged, the total compensation for peer facilities with available data was \$92,022. Therefore, API's total compensation of \$110,874 is 20% higher than the average of the selected peers. While some other facilities are paying more in salary, API has the highest employee benefit costs relative to salary. In FY14, 36% of total compensation was in the form of employee benefits at API, compared to an average of 26% at the peer hospitals. As noted in the analysis of cost trends, the employee benefit cost center has been steadily increasing over the past five years at API.

One facility to consider is South Florida State Hospital, which is the only privately-operated facility in the peer group. While not the lowest in terms of salary, employee benefits expenditures per FTE are substantially lower than the state-operated facilities. This can be considered a potential indicator of benefits relative to total compensation under a private entity.

Direct and Indirect Costs: API and Peer Facilities

PCG analyzed direct and indirect costs as a proportion of total costs. To do so, Worksheet B Part I of the cost report was used. All costs reported under the General Services Cost Centers were classified as indirect costs, while all costs reported under Inpatient Routine Services, Ancillary Services and Non-Reimbursable were classified as direct. Generally, the Non-Reimbursable cost center would be excluded. However, since API includes all tele-health related expenditures under this cost center, PCG found it appropriate to include for our purposes. With this methodology PCG examined indirect and direct costs as a proportion of total costs. The table below summarizes our findings.

²⁷ Data Source: FY14 CMS 2552 Cost Reports, Worksheet A, Worksheet S-3 Part I

Table 6.4.6: Indirect and Direct Costs as a Percentage of Total Costs at API and Peer Facilities, FY14²⁸

Hospital	Indirect Cost	Direct Cost	Indirect % of Total Costs	Direct % of Total Costs
Alaska Psychiatric Institute	\$22,767,730	\$9,352,572	70.90%	29.10%
Anoka-Metro Regional Treatment Ctr.	\$22,019,251	\$25,489,864	46.30%	53.70%
Southern Virginia Mental Health Inst	\$5,750,577	\$6,986,951	45.10%	54.90%
Taunton State Hospital	\$15,174,421	\$5,646,857	72.90%	27.10%
Wyoming State Hospital	\$19,193,326	\$13,684,214	58.40%	41.60%
Small Peer Group Average			55.70%	44.30%
Arizona State Hospital	\$38,462,122	\$24,186,534	61.40%	38.60%
East La State Hospital	\$53,894,395	\$39,552,692	57.70%	42.30%
Florida State Hospital	\$80,160,771	\$40,325,892	66.50%	33.50%
Fulton State Hospital	\$34,726,563	\$53,239,371	39.50%	60.50%
South Florida State Hospital	\$17,852,445	\$11,706,256	60.40%	39.60%
St. Elizabeth's Hospital	\$75,259,001	\$12,794,363	85.50%	14.50%
Large Peer Group Average			61.80%	38.20%

In FY14, 70.9% of total costs were indirect at API. While higher than the average of both the small and large peer groups, API did not have the highest proportion of indirect costs relative to total costs in either group. As seen in Section 6.2, with the exception of Direct Care,²⁹ all of the top five cost centers for both salary and other costs were indirect.

As a subset of indirect costs, PCG also compared reported administrative costs at API compared to its selected peers. When looking solely at reported administrative costs, API is in line with the small peer group, with only a difference of -0.2%.

²⁸ Data Source: FY14 CMS 2552 Cost Reports, Worksheet A, Worksheet S-3 Part I

²⁹ Classified under "Adults and Pediatrics" on CMS 2552 Medicare Cost Reports

Table 6.4.7: Administrative Costs as a Percentage of Total Costs at API and Peer Facilities, FY14³⁰

Hospital	Administrative Cost	Admin % of Total Costs
Alaska Psychiatric Institute	\$5,664,894	17.6%
Anoka-Metro Regional Treatment Ctr.	N/A	-
Southern Virginia Mental Health Inst	\$1,530,437	12.0%
Taunton State Hospital	\$2,781,886	13.4%
Wyoming State Hospital	\$9,223,167	28.1%
Small Peer Group Average		17.8%
Arizona State Hospital	\$10,685,184	17.1%
East La State Hospital	\$436,022	0.5%
Florida State Hospital	\$20,507,530	17.0%
Fulton State Hospital	\$13,226,405	15.0%
South Florida State Hospital	\$3,407,742	11.5%
St. Elizabeth's Hospital	\$12,418,439	14.1%
Large Peer Group Average		12.5%

6.5. Utilization Trends

API is Alaska's only state psychiatric hospital and as such, has been designated by the State as a safety net for inpatient acute care psychiatric needs. The state hospital utilization per 1,000 people is an indicator of access based off of the ratio of patients served and the state population.

For the past five years, API's utilization per 1,000 people has been more than triple the national average for state hospital utilization per 1,000 people, as seen in the table below. In FY15, API's utilization per 1,000 people was 1.66, while the U.S average for state hospital utilization per 1,000 people was 0.44. While there are likely to be multiple contributing factors to this difference, PCG believes that the utilization rate reflects the fact that the hospital is not only a predominantly acute care setting, designed for short stays, but also serves as a care setting of last resort, filling the gaps in Alaska's deficit of sub-acute and long term care settings.

Table 6.5.1: Utilization per 1,000 People in Alaska and US Average, FY11-FY15³¹

	FY11	FY12	FY13	FY14	FY15
API Utilization per 1,000	1.52	1.6	1.68	1.64	1.66
US State Hospital Utilization per 1,000	0.5	0.48	0.47	0.45	0.44

6.6. Admissions

Over the past five years, admission rates at API have been significantly higher than the national average and have continued to grow, despite the fact that the U.S. admission rate has steadily declined, as seen in the table below. In FY15, according to the SAMHSA Uniform Reporting System (URS), of the 1,683 admissions at API, the hospital served 1,219 individual, unduplicated patients, setting an admission rate of 1.38. The US admission rate for FY15 was 0.83.

³⁰ Data Source: FY14 CMS 2552 Cost Reports, Worksheet A, Worksheet S-3 Part I

³¹ Source: Alaska Uniform Reporting System Mental Health 2011, 2012, 2013, 2014 and 2015

Table 6.6.1: Admission Rate³² in Alaska and US Average, FY11-FY15³³

	FY11	FY12	FY13	FY14	FY15
AK Admission Rate	1.25	1.41	1.38	1.33	1.38
US Admission Rate	0.92	0.9	0.85	0.84	0.83

The substantially higher admission rate at API, and the fact that the number of admissions exceeds the number of total unduplicated patients served, together indicate that consumers are cycling through API more than once rather than being served for longer periods of treatment. This becomes more apparent with API's comparatively low average length of stay (ALOS) and high re-admission rates discussed in the next sections.

6.7. Average Length of Stay (ALOS)

API's average length of stay (ALOS) has steadily declined over the past four years. The ALOS indicates the average number of days a patient stayed in a hospital for treatment, and can be a valuable indicator for assessing the appropriate amount of time required for stabilization. The steady decline in consumer length of stay at API is suggestive of growing demand for inpatient acute care psychiatric beds and increasing census pressure on the hospital. As discussed in Section 3.0., API's admission policy was changed in FY 2011 to keep pace with demand for beds in the state, and the hospital adopted an acute care model focused on exclusively on short-term stabilization rather than longer-term in patient treatment objectives. This policy change is evident in Table 6.7.1, when average lengths of stay decrease dramatically between FY11 and FY12, from a 30-day ALOS to an average stay of 15 days. The ALOS has stabilized since then. While the acute care model alleviated some of the census pressure on API, at least temporarily, it also shifted some of the strain onto community behavioral health providers, who formerly relied on API to provide longer periods of residential treatment. Anecdotal testimony from a variety of stakeholders suggests that the restrictive policies have contributed to other stress points within the system, such as longer holds in the Emergency Departments (EDs) as consumers await a court order for admission. Because of waitlists for an evaluation/treatment bed at API, these consumers continue to be detained in EDs until eventual acceptance and transfer to API.

Further, over the past few years, because of API's census pressures, and to cope with the wait times for admission to API, the system has worked hard to get patients to an evaluation facility as quickly as possible. It is now not uncommon for an Anchorage or Mat-Su resident awaiting admission on a court order to API to be accepted by and transferred to either the Fairbanks or Juneau mental health units. It is difficult for patients and their families when the patient ends up being transferred either north or south, where evaluation and treatment beds are available but family visits rarely occur, given the distance and expense. But, of course, this circumstance exists every day for patients from Southwest or Northern and Northwest Alaska, who do not have access to mental health units in their communities or regions at present.

Table 6.7.1 Average Adult Length of Stay (ALOS) in Alaska, FY11-FY15³⁴

	FY11	FY12	FY13	FY14	FY 15
AK ALOS	30	15	11	12	13

While decreased average lengths of stay are sometimes viewed as an indicator of improved efficiency—and in the context of mental health de-institutionalization, important treatment and civil rights goals as well—it is also true

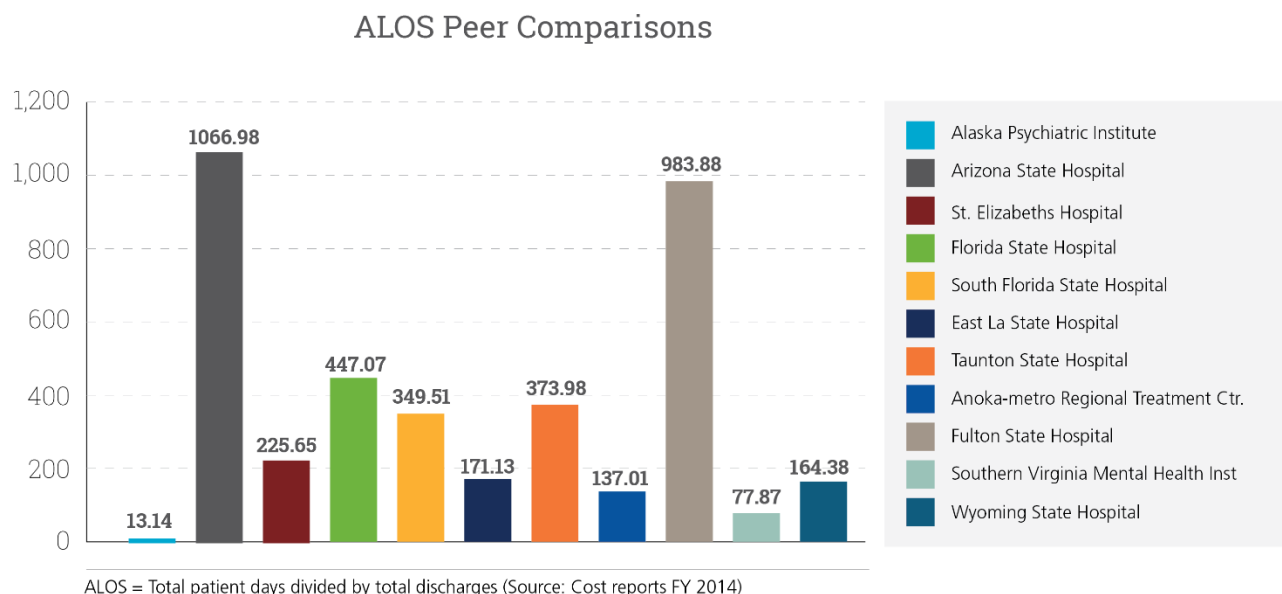
³² Admission Rates = number of admissions divided by total served during the year

³³ Source: Alaska Uniform Reporting System Mental Health 2011, 2012, 2013, 2014 and 2015

³⁴ Source: Alaska Uniform Reporting System Mental Health 2011, 2012, 2013, 2014 and 2015

that beyond a certain threshold, lowered lengths of stay can also indicate inadequate levels of care, and discharge decisions dictated more by the desire to create capacity or to optimize reimbursement than by the treatment needs of a patient. Fueling concerns that decreased ALOS at API has become an indicator of diminished service quality is the fact that ALOS at API is also substantially lower than the lengths of stay seen across the country in other state hospital systems. For example, when comparing API's FY14 ALOS to the other ten peer hospitals and to national averages, API's ALOS was found to be significantly less than even the hospital with the next lowest ALOS. The graph below shows the disparity in API's ALOS compared against other peer state hospitals. The average number of days a patient stayed at API in FY14 was only 13 days, compared to its peer state hospitals, which ranged from 78 to nearly 1,067 days. Adding to this, the average ALOS for the small peer hospitals³⁵ is 188 days³⁶, only further supporting the observation that API's ALOS is extremely low for a state hospital, even when compared to hospitals similar in size. According to this logic, API's exceptionally low ALOS, paired with high readmission rates and the lack of other sub-acute services across the Alaska's behavioral health system, suggest that the hospital may not be able to stabilize patients effectively, given the existing admissions pressure.

Figure 6.7.2: ALOS Peer Comparison, (FY14)



Demonstrating that claim conclusively, however, would require a more nuanced analysis of lengths of stay than what is provided by the hospital's aggregate indicator of length of stay, which is annual patient days divided by annual discharges. In fact, these statistics are not always illuminative, as they obscure major differences in the intensity of treatment received by distinct patient populations. Part of the problem with *average* length of stay, as an indicator, is that the average fails to distinguish the "typical" length of stay for most patients from the significantly longer stays seen within small subsets of a state hospital's patient population. For this reason, *median* lengths of stay can often be better indicators of typical experience, while diverging significantly from a hospital's ALOS. For example, while the national state hospital ALOS for adults was 244 days—mirroring in many respects what was seen in the peer hospital group—the median adult length of stay for state hospitals nationwide was 75 days: a sharp reduction from the average. The median length of stay for API during the period was 5 days, which shows a concomitant drop.

³⁵ Selected small peer hospitals are: Anoka Regional Treatment Center (MN), Southern Virginia Mental Health Institute (VA), Taunton State Hospital (MA) and Wyoming State Hospital (WY).

³⁶ Average ALOS for small peer hospitals = 188.31. Average ALOS for large peer hospitals = 540.70.

Even in FY11, before API's admission policy changes reduced ALOS by half, from 30 days to 15 days, the hospital's reported median length of stay in that year was only 9 days. And while that median was still low by national standards, it was scarcely an outlier in comparison to other state systems. In fact, a fifth of all states reported median lengths of stay of 12 days or lower for their state hospital systems ("systems," not individual hospitals), and six states reported lower medians in their state hospital systems than Alaska. In order for such comparisons to yield insight into appropriate service delivery, it is critical to ask first how the state system is designed, then whether a state hospital is functioning as intended, and only then whether it would be expected to generate higher or lower lengths of stay, as a part of the hospital's specific goals in intervention.

Certainly, it would be legitimate to interpret API's discontinuities with its peers as a sign of its different role, function, and the available resources within Alaska's system when compared to state hospitals in other states. State hospitals like Taunton in Massachusetts, and Anoka Metro in Minnesota, are small, acute care hospitals with similar treatment capacities to API, but unlike API, they are able to rely on a broader set of private freestanding hospitals and inpatient psychiatric units at community hospitals to provide census relief and focused attention on short-stay stabilization. In most states, in fact, partnerships among multiple hospital providers tends to create a natural filtering within the behavioral health system, in which private hospitals act as a gatekeeper and front line for managing acute crisis, in order to allow the state hospital system, if it sees acute patients at all, to receive the more complex cases requiring longer, higher-intensity intervention. No such infrastructure exists in Alaska to support longer, more complex intervention as a routine form of inpatient treatment. Because of API's specific role, with rare exceptions, it is focused exclusively on short-term stabilization.

Given this treatment function, to some extent API already functions more like a private, freestanding psychiatric hospital, which because of greater dependence on insurance and coverage limitations, necessarily assumes the niche of short-stay acute treatment and stabilization in order to maintain financial viability. If treatment at API is more akin to these types of settings than to many other state hospitals, then the question around quality is whether API's length of stay and reported outcomes appear high or low relative to the service delivery patterns seen in these units. Certainly, from the perspective of recommended practice, a 5-day median length of stay is not in itself a worrying indicator. As one expert described evolving standards in private inpatient acute care: "As soon as an in-patient is deemed not imminently dangerous, they must be discharged to a lower level of care. Psychosocial interventions now have more in common with crisis intervention and less with the treatment literature. With average lengths of stays hovering close to a week, the logistics of bringing in family members and arranging for aftercare have become the centerpiece of treatment. A model treatment plan for a length of stay of 5 days is proposed in a recent text of hospital psychiatry."³⁷ While the author acknowledges that some of these trends are driven by the changing economics of reimbursement in private care, it is also true that these treatment protocols have become standard for this type of inpatient facility.

The available evidence suggests that lengths of stay at API are consistent with the wider array of inpatient providers focused on stabilization. For example, according to the federal Agency for Healthcare Research and Quality (AHRQ), its Healthcare Cost and Utilization Project (HCUP) data reveal that ALOS for schizophrenia, bipolar disorder, and other mood disorders—the most common diagnoses at API as well as most psychiatric hospitalizations—is typically 10.4 days for schizophrenia and 6.6 days for mood disorders. These are ALOS comparable to trends at API.³⁸ Additionally, analyses of the inpatient populations covered by the Medicare Inpatient Psychiatric Facility Prospective Payment System have shown similar patterns, as well as major differences between state and private providers. A study of 1999 data for this population indicated an ALOS of 11.8 for non-profit psychiatric hospitals, and 12.3 for for-profits, as opposed to 21.9 days on average for public hospitals, with a median of 9 days for the private hospitals versus 13 for the public psychiatric hospitals.³⁹ Similar data from 2008 indicated a 12.4-day ALOS for private freestanding hospitals, in comparison to 28.7 days for

³⁷ L. Mark Russakoff. *Psychiatric Bulletin* (2014), 38, 230-235.

³⁸ AHRQ, HCUP Statistical Brief #189 (May 2015).

³⁹ Philip G. Cotterill and Frederick G. Thomas. "Prospective Payment for Medicare Inpatient Psychiatric Care: Assessing the Alternatives." *Health Care Financing Review*. v.26:no.1 (Fall 2004), 85-101.

government hospitals. Public and private psychiatric units were far more similar, with 12.2-day ALOS for government-operated psychiatric units, and 11.2 ALOS for private facilities.⁴⁰

These figures do not necessarily indicate diminished service quality at API, but rather that the hospital appears to operate more like a private provider, even if it is financed and staffed as a public provider.

6.8. Readmissions

Similar service trends are evident in API's readmission rates. For the past five years, API's 30- and 180-day readmission rates have been 160%-180% times the national average for other state psychiatric hospitals. Readmission rates are among the most important measures for evaluating the effectiveness of treatment, with a high readmission rate suggesting either deficiencies in inpatient treatment or the inadequacy of community treatment to sustain consumers within the community. There is an acknowledged lack in the range of crisis respite and sub-acute and step-down services across Alaska's behavioral health system of care, but API's high readmission rates have also led to concerns that the hospital may not be stabilizing consumers sufficiently prior to discharge. As seen in its ALOS statistics, API's admission policy is likely the reason for a bump in readmission rates from FY11 to FY12. During that time, the 30-day readmission rate increased by 2 percentage points, and the 180-day readmission rate increased 6.4 percentage points.

Table: 6.8.1: 30 Day and 180 Day Readmission Rates in Alaska and US Average, FY11-FY15⁴¹

	FY11	FY12	FY13	FY14	FY15
AK 30-day Civil Readmission Rate	13.0%	15.6%	16.7%	15.9%	15.5%
US 30-day Civil Readmission Rate	9.0%	8.9%	8.6%	8.2%	8.2%
AK 180-day Civil Readmission Rate	26.5%	32.9%	32.9%	31.9%	30.5%
US 180-day Civil Readmission Rate	20.5%	19.6%	19.8%	18.8%	18.5%

PCG's analysis suggests that API's comparative readmission rates, like its ALOS statistics, need to be understood within the terms of the specific types of treatment provided by the hospital rather than the service delivery standards found within many other state hospital systems. Once again, when API's readmission rates are considered in the context of non-state hospital providers offering similar interventions aimed at short-term stabilization, then the hospital's readmission rates fall within expected ranges. For example, the readmission rates seen within the HCUP data vary from 22.4% 30-day readmission rates for schizophrenic patients to 15% 30-day readmission rates for mood disorders.⁴² National readmission data available from the Medicare population presents a similar picture. The overall 30-day readmission rate for this population is 15%, which varies slightly, from 16.1% to 14.4%, depending on whether the inpatient bed is a part of a freestanding psychiatric hospital or a psychiatric unit.⁴³

While the possibility that API's higher readmission rates relative to its state hospital peers are due to diminished service quality cannot be discounted, it is also important to point out that API is relevantly dissimilar to many other state hospital systems in the type of treatment it is able to provide. It is a limitation of Alaska's behavioral health system that inpatient capacity does not exist to offer longer-term rehabilitation options. However, this deficit appears to be due, not to the quality of treatment provided by API, but to the lack of resources within the system as a whole. Certainly, it would be unrealistic to expect that a privatized provider would achieve significantly better

⁴⁰ The Moran Company. *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System*. May 2013.

⁴¹ Alaska Uniform Reporting System Mental Health 2012, 2013, 2014 and 2015

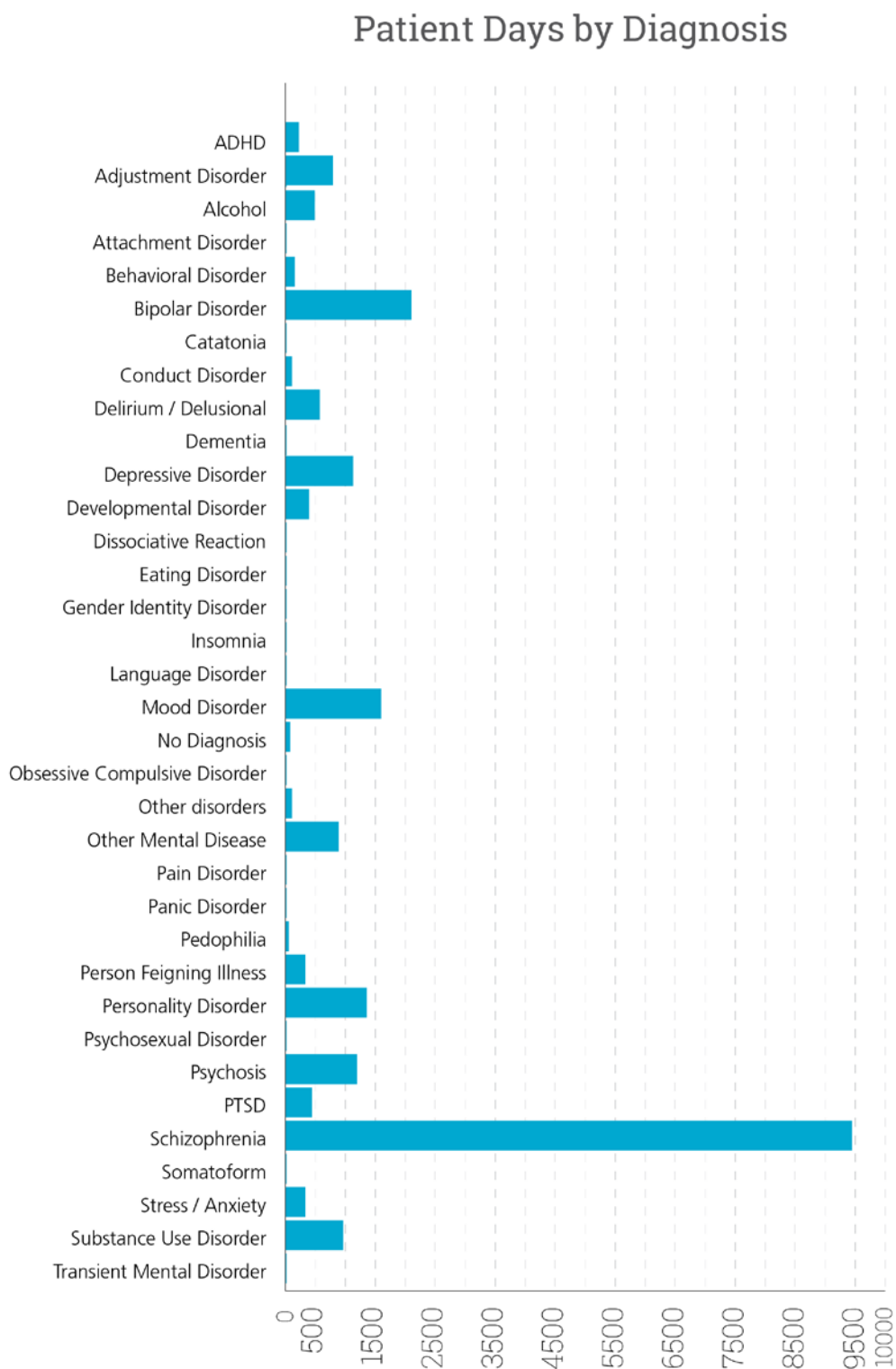
⁴² AHRQ, HCUP Statistical Brief #189 (May 2015).

⁴³ The Moran Company. *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System*. May 2013.

readmission rates than the current level, relying solely upon the present resources available for inpatient treatment within the state.

6.9. Service Population Characteristics

The diagnosis make-up of API's population is appropriate with the exception of a small population of consumers suffering from dementia. In analyzing the diagnosis groupings, we can assess whether or not API is the appropriate setting for their current population. Historically, the diagnosis with the highest patient days are bipolar disorder and schizophrenia, which are appropriate diagnosis for an acute psychiatric hospital. However, in FY15, there were 454 dementia patient days and the average patient days for dementia since FY12 has been 354 days. Stakeholders shared that API frequently takes in long-term dementia consumers because they are not only the catch-all acute care psychiatric hospital but have become the safety net for difficult to place sub-acute consumers. However, given that API is an acute psychiatric hospital, dementia is not an appropriate diagnosis for API but API bears that responsibility because there is no other alternative. Figure 6.9.1 provides an overview of FY15 patient days per diagnosis at API.

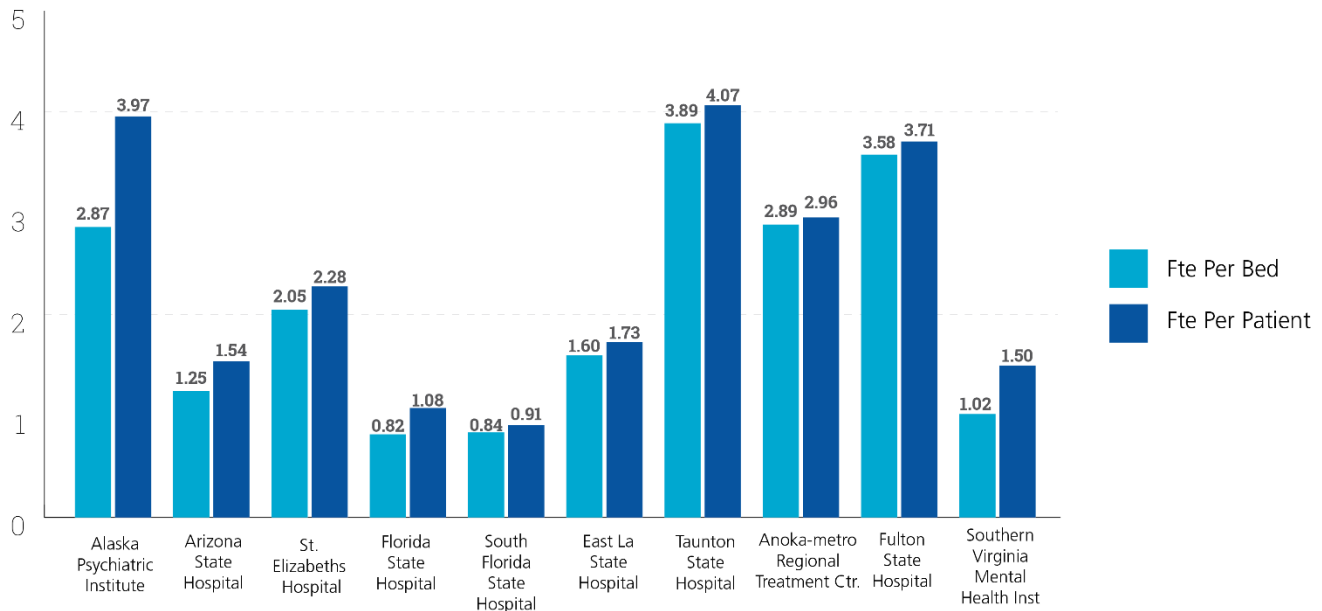
Figure 6.9.1: Patient Days by Diagnosis, FY15

6.10. Staffing

In comparison to peer hospitals, API operates at higher staffing levels, both as function of beds and average patient census. The graph below illustrates the number of FTEs per bed and per patient for API in comparison to other peer state hospitals for FY14. Relative to peer hospitals as a whole, API is clearly on the upper end of staffing levels. However, there appear to be significant differences between large and small facilities in staffing levels, potentially indicating different economies of scale. This difference once again suggests that comparison to large hospitals may be inappropriate. However, even in comparison to small peer hospitals, API staffing exceeds typical staffing levels, without obvious improvement in quality of care.⁴⁴

Figure 6.10.1: API Staffing Ratio

API Staffing Ratio (FY14)



FTE PER BED = TOTAL FTE divided by TOTAL NUMBER OF BEDS (Source: Cost report FY 2014)

FTE PER PATIENT = TOTAL FTE divided by TOTAL PATIENT DAYS/365 (Source: Cost report FY 2014)

6.11. Hiring and Retention

Hiring and retaining qualified mid-level staff has been a historical problem at API. However, difficulty hiring and retaining is a problem felt throughout Alaska, largely due to its geographical location. As a result, the shallow labor pool of psychiatrists, physicians, physician assistants (PA), advanced nurse practitioners (ANP) and mid-level nurses has created increased competition among providers to recruit and retain qualified employees. As of August 2016, API was staffed by seven psychiatrists and three mid-level providers, including two nurse practitioners and a physician assistant; however just one or two resignations could cause operational deficiencies including temporary bed closures, as was seen in November 2015, when the Katmai unit temporarily closed. Historically, API has filled vacancies through the use of locum tenens. However, this has proved to be problematic due to the substantially higher costs of locum tenens compared to regular staff, and lower quality of care.

⁴⁴ Average FTE per bed for small peer state hospitals = 2.6. Average FTE per patient for small peer state hospitals = 2.84 (FY 2014)

While API does not currently employ any locum tenens, low compensation relative to the local competition will remain a barrier to hiring and keeping the necessary staff. According to data gathered by the Medical Group Management Association, compensation at API is 30% lower than that of the private sector. Paired with the strenuous nature of working in a high-volume, acute psychiatric facility, providers at API often leave to work in private sector area hospitals where they will receive more compensation and have more stable schedules. Bargaining units' salary scales make it difficult, if not impossible, to adjust compensation for labor-protected mid-level staff, such as PAs, ANPs, and nurses. While API is currently fully staffed, it is at high risk of losing staff, given the competitive nature of the market, relatively low compensation, along with heightened work environment pressures. These factors are important to recognize, because insufficient mid-level staff can seriously reduce quality of care and impede service delivery.

7.0. PRIVATIZATION REQUIREMENTS AND ASSUMPTIONS

7.1. Legal Analysis and Capital Cost Considerations

As illustrated by the breadth of other states' privatization efforts described in Section 5.0, privatizing a State-operated health care facility can take many forms. Depending on the scope and structure of such contractual arrangements, different types of privatization may pose different legal and policy related challenges. This section describes implications related to statutory requirements, contractual obligations, and asset considerations that serve to inform the analysis of potential new operating models for API.

STATUTORY REQUIREMENTS

API serves both forensic and civil patients who require a secure, inpatient setting for mental health treatment. As such, statutory requirements impacting API's patient population include titles describing both the State's overarching mental health program and specific requirements of criminal procedure for persons with mental health conditions.

AS 47.30.660 establishes the powers and duties of the Department of Health and Social Services to include the requirement to "designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders," and the ability to "delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed" by this section. This statutory section also allows the Department to "enter into contracts with treatment facilities for the custody and care or treatment of persons with mental disorders." Contracts under this section are governed by AS 36.30, which is the State Procurement Code. The combination of requirements set forth in the State Procurement Code appear to support the Department's ability to contract for operation and/or maintenance of a treatment facility under a privatization model.

For patients who are involuntarily committed, AS 47.30.760 requires that patients will be placed in an available facility that is closest to the patient's home community, or otherwise best suited for the patient's condition and meets the patient's need for ongoing connection to family and friends. This section also requires that "treatment shall always be available at a state-operated hospital." The term 'state-operated' is not defined in statute and can be interpreted to include state facilities that operate under various privatization models. This requirement does however obviate the need to define patient admissions processes under privatization, preventing patient selection or treatment refusal by a contractor. The requirement for available treatment at a state-operated facility is reiterated for individuals who are converted from involuntary outpatient to involuntary inpatient treatment at AS 47.30.800.

Title 12 defines the processes impacting persons arrested for criminal offenses, from investigation through incarceration. Title 12 does not specifically obligate API to act as the sole provider for any of the forensic services described above. However, placement for justice-involved individuals may prove difficult outside of state-controlled facilities. Provisions regarding the availability of beds and requirements to accept referrals, as noted for civil patients above, would also play a critical role in privatization of forensic units at API. Additionally, as the rules that govern involuntary commitment may apply to those found not guilty by reason of insanity, the requirements for available treatment at a state-operated facility also directly apply here.

As described above, no part of Title 47 or Title 12 was identified as explicitly preventing privatization of API at any operational level. However, should the State choose to privatize all or most of API's operations, statutory changes may still be required. For example, one option that has been exercised in Alaska and other states is the establishment of a public corporation or joint operating agreement to manage the facility. Public corporations are established through statute, codifying details of the corporation's obligations including, but not limited to:

- Descriptions of board representation and appointment processes;
- Board responsibilities and voting processes;

- Conflict of interest standards; and,
- Contracting and oversight requirements.

The Alaska Gasline Development Corporation, as established at AS 31.25, provides one of many examples of the scope of requirements that must be codified to create this type of public-private entity.

CONTRACTUAL OBLIGATIONS

While few statutory changes may be required, other statutory requirements may still impact the implementation of full or partial privatization. These requirements must be reflected in any resulting contractor agreements.

Liability and the application of State immunity presents one of the most significant changes for API under privatization. Currently, as employees of a state entity, API employees are protected from civil action when acting in the scope of their employment as established at AS 09.50.253, as defined below:

“(c) Upon certification by the attorney general that the state employee was acting within the scope of the employee's office or employment at the time of the incident out of which the claim arose, any civil action or proceeding commenced upon the claim in a state court is considered an action or proceeding against the state under the provisions of this title, and the state is substituted as the party defendant. The civil action or proceeding certified under this subsection is subject to the same limitations and defenses applicable to an action or proceeding against the state. The attorney general or the attorney general's designee shall defend the civil action or proceeding on behalf of the state.”

When the State replaces the individual employee(s) in the proceedings described above, limitations designed to prevent excessive litigation against the State take effect. However, these protections may not apply under various privatization models. Full privatization and the establishment of public corporations generally require that the contractor or corporation operates independent of the State and thus can “sue or be sued in its own name,” as established in AS 10.06.010. This liability may well introduce a level of risk to any contractor that could be greater than that experienced at present by the state. Under partial privatization, different operational units present different degrees of liability risk. For example, direct care providers may be more vulnerable to litigation than other operational units as they hold a higher level of responsibility for the well-being of API's patients.

Limited liability for the State under privatization may be solidified through contractual or statutory means. One example of contractual provisions that may be considered in a privatized model can be found in the terms governing the use of Locum Tenens temporary service providers for API, as included below:

“The Provider shall indemnify, hold harmless, and defend DHSS from and against any claim of, or liability for error, omission, or negligent act of the Provider and/or Locum Tenens under this Agreement. The Provider shall not be required to indemnify DHSS for a claim of, or liability for, the joint negligent error or omission of the Provider and/or Locum Tenens and the independent negligence of DHSS. If there is a claim of, or liability for, the joint negligent error or omission of the Provider and/or Locum Tenens and the independent negligence of DHSS, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis.”

The State may also consider examples of statutory liability limitations, such as those defined for the Village Public Safety Officers (VPSO) program at AS 09.65.280, as follows:

“Notwithstanding another provision of law, the state and its officers, agents, and employees are not liable in tort, except for an act or omission that constitutes gross negligence or reckless or intentional misconduct, for damages for the injury to or death of a person or property damage resulting from the supervision of, training of, actions of or failure to act of, or use of or failure to use village public safety officers in communicating with or monitoring the activities of persons on probation or parole.”

Through the VPSO program, regional native non-profit organizations or boroughs hire individuals to act as first responders for rural Alaskan communities. The hiring entity consults with the Alaska State Troopers on hiring decisions, and the Alaska State Troopers provide oversight for law enforcement activity. However, VPSOs are not state employees. The liability requirement above, therefore, specifically limits the state's liability with respect to the actions of Village Public Safety Officers.

Additionally, the State must design contractual obligations, and associated oversight and monitoring practices, to reflect statutory requirements governing patients' rights, certain operational processes, and quality provisions. Examples of such provisions, along with the applicable statutory reference, are provided below.

- **Discharge Planning:** AS 47.30.825 defines a set of patient medical rights, which includes a provision requiring that each patient shall be given a discharge plan the type and amount of care required after discharge, along with other steps the patient may take to benefit his/her mental health. The patient has the right to participate in plan development, and a copy of the plan must be provided to the patient as well as the patient's guardian or other adult designated by the patient for communication purposes.
- **Patient Grievance Procedures:** AS 47.30.847 establishes the patient's right to bring grievances regarding treatment, care, or other rights to "an impartial body within an evaluation facility or designated treatment facility." The facility is required to develop a formal grievance process and designate a staff member trained in mental health consumer advocacy to assist in bringing such grievances for review.
- **Joint Commission Accreditation:** API is currently accredited by the Joint Commission. The Joint Commission is an independent, non-profit organization that accredits and certifies more than 21,000 healthcare organizations nationally. Accreditation reflects a hospital's commitment to meeting minimum operational and quality standards⁴⁵. Under privatization, the chosen contractor may be required to maintain accreditation as part of its quality assurance program. AS 18.20.080 provides that the Department will inspect hospital facilities annually, but may accept Joint Commission accreditation in lieu of inspection for the year in which the accreditation was granted. The State may consider whether to apply stricter standards for inspection for a private contractor and the relative cost and benefit of such oversight processes.
- **Records Retention and Information Sharing:** AS 18.20.085 establishes the requirements for patient records retention that apply to all hospitals, including those providing psychiatric treatment. Any contractor managing operations of API will be required to establish processes consistent with these requirements and their associated regulations. The contractor must similarly establish data storage requirements, processes and oversight to ensure compatibility with the Health Insurance Portability and Accountability Act (HIPAA).

Note that stakeholders interviewed for this study urge the review and revision of statutory obligations with respect to patients' rights and patient care, as such standards are viewed as outdated.

Lastly, different privatization models require unique consideration of the three different labor unions that currently represent the various staff working at API. Full privatization, on meeting the requirements outlined in the current labor agreements, will most likely result in removing API employees from these unions. A public corporation or partial privatization, however, may be designed to allow continuation of some labor agreements under new management. Employees at API are covered by the three different labor agreements. Only physicians, pharmacists, the Director of API, and Chief Operating Officer are exempt, and are not unionized.

⁴⁵ <https://www.jointcommission.org/>

7.2. Service Delivery Considerations

PEER COMPARISONS

In order to gain a better understanding of operations at API, PCG compared the hospital to other state-owned psychiatric hospitals. The purpose for doing so was two-fold: 1) to assist in identifying potential staffing inefficiencies at API, and 2) to establish minimum thresholds for staffing reductions. PCG compared the staffing levels at API to a subset of the previously established group of peer facilities in order to understand current hospital operations as well as determine adequate staffing for a hospital providing acute inpatient psychiatric care. PCG selected a group of hospitals whose Medicare cost report data was readily available and whose service delivery characteristics are well-known. At the time of this analysis, FY15 cost report data was the most recent and complete for all of the selected hospitals. These hospitals ranged in size from a small, 45-bed facility that provides acute inpatient care exclusively, to larger, 350+ bed facilities offering both acute and long-term care. The selected peer group is included in the table below:

Table 7.2.1: Selected Peer Hospitals

Peer Hospitals	Beds	Group	State	Type
Arizona State Hospital	299	Large	AZ	State
Fulton State Hospital	354	Large	MO	State
South Florida State Hospital	350	Large	FL	Private
St. Elizabeth's Hospital	292	Large	DC	State
Taunton State Hospital	45	Small	MA	State
Anoka Regional Treatment Center	136	Small	MN	State

The peer hospitals fall into two groups: the large peer group and the small peer group. These two groups established a range for comparison for contextualizing API's own staffing profile. Included in the large peer group is the privatized state hospital, South Florida State Hospital. Looking at SFSH, in particular, served as an introductory step in understanding differences between state-operated and privately-operated hospitals. Furthermore, comparative staffing for these hospitals' different functions and capacities enabled PCG to evaluate API's operations on its own terms. In accounting for the sometimes significant differences in staffing within the peer groups, PCG was better able to appreciate the staffing levels required for API's resource-intensive acute care functions.

Given that staffing expenditures compose the majority of API's overall budget, PCG aimed to assess API's reported FY15 staffing levels relative to its peers. It is important to establish a staffing baseline to gain a better understanding of personnel needs and identify the aspects that make API unique. For these reasons, in the table below, PCG compared FTEs per patient at API to the large hospital peer group and small hospital peer group.

Table 7.2.2: FTEs per Patient⁴⁶

	API	Large Peer Group	Small Peer Group
Admin, Indirect	1.16	0.76	1.08
Nursing (RNs and PNAs)	1.96	1.74	1.83
Other Medical Staff	0.19	0.08	0.18
Rehabilitation	0.09	0.02	0.08
Psychology, Psychiatry	0.24	0.17	0.22
Social Work, Counseling	0.18	0.05	0.17
Total FTE per Patient	3.82	2.76	3.57

As shown in the table above, API reports higher FTEs per patient than both peer groups in all staff categories. Compared to the large group, API shows 1.06 more FTEs per patient as a whole. This difference is largely due to the diversity of services performed at a large facility versus a smaller facility, as well as the significantly higher administrative overhead observable at smaller facilities. As previously mentioned, larger facilities often provide long-term care in addition to acute psychiatric care, which is far less intensive and requires less direct staffing.

The table above also illustrates that API more closely resembles the smaller facilities that focus extensively on acute psychiatric care. While API's staffing is comparable to the small peer hospitals, the fact that API's number of staff hours per patient is higher even than its small peers in every employee category suggests that reductions in staffing are potentially viable, and would likely be pursued by a private entity in search of efficiencies.

Although a reduction in overall FTEs creates the potential for lower staffing expenditures, the opportunity for cost savings must be closely evaluated in terms of impact on staffing requirements, and the implications for service delivery thoroughly weighed. In this respect, the peer hospital comparisons were crucial for establishing safe thresholds for reducing staff hours without negatively affecting service delivery. PCG's peer comparisons with other small, acute care hospitals directly informed the two types of scenarios devised to measure financial and service delivery impact for each of the privatization options. For each privatization option, we estimated the costs of operating API with the status quo staffing levels evident in FY15, as well as costs associated with a "recommended staffing" level, whose direct care staffing levels are based largely on the small peer group staffing averages:

- **Baseline Staffing Scenario:** This scenario is simply the estimated costs of a privatized API with the staffing levels and service utilization reported in FY15. This scenario allows for an immediate comparison of differences between cost profiles of a public and private operator, employing exactly the same resources. This scenario does not build in any additional staffing efficiencies for any of the privatization options.
- **Recommended Staffing Scenario:** This scenario models API after applying PCG's thresholds for reduced staffing, assuming a cap on cost savings found in limiting numbers of staff while maintaining safe direct care staffing ratios and effective administration.

These scenarios allowed PCG to evaluate the feasibility of our identified privatization options under a variety of conditions, using different staffing and financial assumptions to provide the State with a more comprehensive understanding of the implications of privatization. While the reductions across the different staffing scenarios generally aimed to reduce administrative hours, the recommended reductions typically decrease direct care staff to levels similar to API's smaller peer hospitals. These staffing patterns remain reflective of service delivery in hospitals solely providing acute inpatient psychiatric care.

⁴⁶ FY15 CMS 2552 Cost Reports, Worksheet A

The Small Hospital Peer Group proved to be a valuable guide in informing PCG's recommendations on appropriate staffing reductions. Outside of a handful of clinical guidelines on minimum staffing ratios for different types of nursing, there are few established standards on appropriate staffing levels beyond the standard practice of peer institutions. Since required staffing varies by factors as multifarious as the type of psychiatric service, the mix of patient acuities, the time of day of patient care, and even the floor plan and physical layout of the facility, understanding the particular staffing needs of a hospital usually requires a detailed clinical review that would be beyond the scope and resources of this feasibility study. Fortunately, some of these types of reviews have been conducted at API in recent years, and PCG has relied on these evaluations where available, along with detailed feedback from former and current API administrative and direct care staff to estimate the staffing needs for each of API's residential wings. As a final test of the plausibility of the proposed staffing reductions in each of our staffing scenarios, PCG compared the overall FTE levels with standard practice in other small, acute psychiatric hospitals to determine whether the models aligned with the staffing of peer hospitals or whether reduced staffing suggested potential diminishment in the hospital's ability to maintain service standards.

STAFFING REQUIREMENTS

Previous examples of privatization have shown that, as a means of achieving cost savings, a private operator often reduces costs by reducing staffing. Presumably, an incoming contractor at API would attempt to run the facility as efficiently as possible, thereby maintaining only the necessary levels of personnel. While any reduction in overall staff would yield a reduction in the associated personnel costs, PCG examined the service delivery implications of possible staff reductions to prevent overstating or understating opportunities for cost savings. While the facility as well as the State could benefit from leaner API operations, there are warranted concerns that minimizing staff could yield negative quality outcomes. In short, if staffing falls too low, there could be negative consequences for patient care, as well as increased risk for staff and patient injuries, strained relationships with community providers, and damage to the facility's reputation.

PCG analyzed existing literature on staffing standards, the staffing patterns of peer facilities, as well as previous clinical and organizational reviews of API. These served as a guide in determining the adequacy of the hospital's staffing arrangements. Stakeholder feedback about staffing patterns served as an additional source of information on potential workforce reorganizations and reductions that could be implemented at the hospital to improve efficiency, as well as differences between the organizational capacities and staffing expectations of a private manager versus a state-managed facility. Based on this analysis, we modeled a scenario of API operations with recommended reductions in workforce. Rather than assuming a simplified model of FTE reductions applied proportionately across the hospital, our goal was to take a targeted approach in creating various staffing scenarios that would be as predictive as possible of the management resources and decisions of a private operator.

In developing our staffing models, PCG paid special attention to two staff types: administrative staff and nursing staff. As evidenced in our peer hospital analyses, administrative staffing at API is high in relation to its peer facilities. Elevated staffing levels appear to be most pronounced for administrative personnel and for nursing personnel. For example, the administrative level at API is 1.16 FTEs per patient, while it is 1.08 FTEs per patient on average at small hospitals, and 0.76 FTEs among the larger hospital group. While it is unlikely that API could achieve the ratios of a larger hospital, given the economies of scale involved, it is certainly possible that API's administrative resources could be reduced to the levels of its small, acute care peers, and remain efficient. Of course, this indicator is not the only evidence of potential administrative overstaffing at API. Several stakeholders also commented that they perceived administrative overhead to be high at API. Additionally, PCG's analysis of personnel costs revealed relatively high usage of overtime by administrative staff, suggesting that administrative time could be used more efficiently than it is currently. As discussed elsewhere in this section, PCG also assumed an incoming contractor would already have built-in administrative infrastructure that could be harnessed, further reducing the need for some current administrative positions. For example, a private company with existing quality improvement resources or information technology infrastructure would likely host these functions at the corporate level rather than at the facility, absorbing these costs into the broader enterprise. PCG considered these factors

as we created our various cost models. While API could certainly increase administrative efficiencies in its current state, privatization could bring additional means for reducing costs.

Nursing proved to be another area in which FTEs at API appeared to be high relative to the small hospital peer group. Nursing staff at API make up the largest proportion of API staff, composing 58% of FTEs when including Registered Nurses (RNs), Psychiatric Nursing Assistants (PNAs), and nursing administrators⁴⁷. Nursing staff also provide the majority of direct care, as each of the five units must be staffed at all times. Importantly, nursing ratios for small and large hospitals appeared to be less variant than many other types of staff, suggesting that they play a fundamental role in direct care, with only limited latitude in reducing staff-to-patient ratios. The nursing FTE average at small hospitals was 1.83 FTEs per patient, which in comparison to 1.74 FTEs per patient on average at large hospitals, is not as significant an increase as the difference observed in administrative ratios. However, API's nursing levels are elevated well above its small hospital peers, at 1.96 FTEs.

Of course, “overstaffing” is not the only explanation for why API's nursing FTEs are higher than its peers. If API is in fact caring for patients with higher acuity needs than patients seen at other state hospitals—which typically operate in behavioral health systems with more robust community care—then the higher levels of nursing staff at API might be entirely justifiable. Since there are no easily quantifiable methods for measuring differences between patient acuity in various state systems, PCG cannot rule out that explanation as a possibility. On the other hand, a number of sources in our study suggested specific areas in which nursing hours could be reduced without negatively impacting service delivery. For these reasons, we estimated that API could achieve nurse staffing levels more aligned with what is seen at other small, acute care hospitals.

After projecting reduced levels based on administrative redundancy, improved efficiency, and other expectations about the private management practice, PCG devised our “Recommended Staffing” scenario, which indicates staffing levels that are more comparable to other small hospitals. The table below shows the FTEs per patient reflected in our full privatization model, as well as those found in our model of continued state management with improved efficiencies:

Table 7.2.3: “Recommended Staffing” FTEs per Patient⁴⁸

Staff Type	Recommended Privatized Staffing	Recommended State-Managed Staffing	API Baseline	Large Peer Group	Small Peer Group
Admin, Indirect	0.93	1.03	1.16	0.76	1.08
Nursing (RNs and PNAs)	1.84	1.84	1.96	1.74	1.83
Other Medical Staff	0.19	0.19	0.19	0.08	0.18
Rehabilitation	0.09	0.09	0.09	0.02	0.08
Psychology, Psychiatry	0.24	0.24	0.24	0.17	0.22
Social Work, Counseling	0.17	0.17	0.18	0.05	0.17
Total FTE per Patient	3.49	3.59	3.82	2.76	3.57

This table illustrates the implications of PCG's staffing recommendations for each of our overall privatization options, in comparison both to API's FY15 baseline levels and to the hospital peer groups.

When looking at total staff FTEs per patient, PCG's recommendations imply that a private operator would be able to operate a little more leanly than a state operator: 3.49 FTEs per patient versus 3.59 under continued state management. This is a difference of approximately 7 FTEs in staff time. The major reason for this difference is that a private operator would be able to take advantage of administrative efficiencies unavailable to a state-operator, including IT infrastructure and administrative oversight already available at the enterprise level that,

⁴⁷ Alaska Psychiatric Institute, “2015 Dollars Report by Department”, “2015 Hours Report by Department”

⁴⁸ FY15 CMS 2552 Cost Reports, Worksheet A

under a state operator, would continue to remain unique to API and borne solely by its budget. The staffing differences between PCG's private and public options are restricted solely to administrative personnel. Our recommendations for reductions to other staff types would be available to either type of provider, and we have applied them consistently across each privatization option. Significantly, applying these reductions yields a state-managed staffing level that is basically comparable to the small peer hospital average. It is also intuitive that a private provider would have an overall staffing level lower than the small peer group, as each of the hospitals in the peer group are state-managed, and in most respects, are constrained by the same forces as a state-managed API.

Staffing levels for many of the different staff types do not change significantly between the Baseline Scenario and the Recommended Staffing Scenario, typically because it was not evident to PCG that staff hours could be reduced in any way without negatively impacting service delivery. A prominent example of the reason for our conservatism with direct care functions can be seen in the Psychology and Psychiatry category. PCG determined that staffing levels should remain the same for this category across the different scenarios, the reasons for which has been amply demonstrated in recent years due to periodic closure of some wings of the hospital due to psychiatry shortages. PCG's rationale for reducing administrative staffing levels for both private and public options are detailed in later sections, as they are based on targeted functions within the hospital.

Finally, aside from administrative reductions, the table also shows that PCG's staffing recommendations involve significant impacts to nursing department staffing levels (both RN and PNA levels). Our reductions are based on the assumption that API can continue to operate efficiently at nursing staff levels comparable to the small hospital peer group—with 1.84 nursing FTEs per patient, as compared to 1.83 in the small peer group. However, PCG has attempted to justify this assumption, both by comparing our recommended staffing levels to available staffing ratio standards, as well as reviewing minimum staffing requirements at API and trends in demand for elevated staffing needs for high acuity patients.

In the first instance, PCG found that clinical standards do exist for RN staffing in a range of different health care settings, including acute inpatient psychiatric care. Within the last decade, studies by the California Nurses Association have established standards for nursing ratios across settings that have become enshrined in state law. In accordance with California's Safe Staffing Ratio law, providers in the state must maintain a minimum 1:6 staffing ratio of RNs to patients, which also assumes an additional array of support nursing staff and that other nursing types are not substitutable.⁴⁹ PCG calculated the reported FTEs of non-administrative RN staff at API in FY15 against the hospital's reported patient days, revealing that there was an average census of 65 patients at the facility at any given time, along with 10.7 RNs on duty on average. Based on this calculation, the average RN staffing ratio at API in FY15 was 1:6.07, approximating recommended practice.

Because API's RN coverage already hovers at the staffing standard, PCG was conservative in reductions proposed for RN FTEs. However, our models do entail small reductions in RN FTEs, from a baseline of 44.95 FTEs to 42.07. In other words, PCG's Recommended Staffing Scenario assumes almost 3 fewer RNs, which amounts to a RN-to-patient ratio of 1:6.49. There are a number of justifications for assuming this reduction, despite the fact that it falls below the minimum threshold set by the California standard. The first is that our "recommended staffing" assumptions have to be understood within the context of our attempt to model the likely behavior of an actual private operator and not just best practices. That is to say, the feasibility study aims to predict what a contractor **would** do, not what it **should** do. Since the State of Alaska has not established minimum staffing requirements along the lines of the California law, there is no reason to think that a private operator looking for cost savings or attempting to increase its profit margin would staff to the California standard if not required to do so. Rather, it would probably endeavor to substitute RN hours with less costly alternatives, at least to the extent that it could do so without significant effect to outcome and also still maintain API's Joint Commission accreditation. In accordance with this logic, PCG's proposed staff reductions assume that this sort of decision would be a feature of the pursuit of new efficiencies. And to the extent that this serves as a model of

⁴⁹ California Nursing Association, "The Ratio Solution", 2009

improved efficiency in the case of private operator, we have also applied the same reductions in our model of new efficiencies under continued state management, according to the logic the State would not find this reduction acceptable for a private operator, but not for a public one.

The second justification for this reduction is that the California standard is exceptional to some degree. PCG is unable to identify another state that has implemented this standard, and the passage of the law in California proved to be controversial. Furthermore, the 1:6 staffing ratio is in itself already something of a compromise between clinical standards and political and fiscal realities, as the study on which the law is based concluded that a 1:4 nursing ratio is really optimal. While this RN staffing ratio may represent industry best practices, it is clear from PCG's hospital peer group comparisons that the ratio does not reflect industry standard practice, as the nursing ratios indicated in other state hospitals illustrate significantly higher ratios when compared to their patient days. In the interest of balancing competing demands among the need and desirability of finding cost savings, the task of predicting likely provider behavior, and to identify potential impacts to service delivery, PCG ultimately determined that RN staffing levels could be reduced by a modest amount. However, we have no legitimate basis for thinking that RN levels can be lowered below a staff-to-patient ratio of 1:6.5 without harming the quality of nurse training and ultimate patient outcomes.

As an additional check on whether PCG's proposed nursing reductions could be implemented without detriment to API's service delivery, we calculated the hospital's minimum nursing needs, based on the physical layout of its treatment units and its typical needs for elevated nursing ratios for one-on-one monitoring, known as Close Observation Status (COS). As previously noted, API is divided into five different units, serving populations of varying severity, with an unequal number of beds in each unit, as well as a combination of single and double patient bedrooms on each unit. Each of these units requires at least one RN at all times, and 1-3 supporting PNAs, depending on time of day, bed occupancy, and patient acuity. At a minimum, API requires five RNs and seven PNAs staffing the floor at every moment: 12 nursing department staff total. During the day, when patients are active, the minimum can be eight PNAs.

Based on COS statistics recorded by API, the facility often appears to have 4-6 patients on close observation at any given moment, meaning a 1:1 nursing ratio at minimum, and—depending on behavioral characteristics—a 2:1 ratio. When these minimum staffing requirements are broken down to the needs of an average 24-hour period, it is evident that the units require a minimum of 120 hours of RN time per day and 192 hours of PNA time. API also tracks additional staff time attributed to COS, which came to roughly 122 additional hours needed per day, or 5.09 extra nursing department staff on hand. Altogether, 434 nursing staff hours are required on average every day, the equivalent of 18.1 nurses on the floor at every moment.

PCG then converted the nursing FTE estimates of our Recommended Staffing scenario into total paid hours. Accounting for the fact that approximately 15% of these hours represent non-productive time (holidays, vacation, sick time), it is also reasonable to assume that another 10% of these hours are not direct care time, but are spent in activities such as education, administration, and quality assurance. Supposing, then, that these paid hours are 75% "productive," PCG's recommended staffing comes to 510 daily hours, the equivalent of approximately 21.25 nursing staff. This figure assumes then, that there are 3.15 more nursing staff working every day than the bare minimum required to maintain the basic functionality of the units. If 70% productivity is a more accurate reflection of the proportion of direct care versus administrative responsibilities, then there would be closer to 1.5 additional nursing staff on the floor than the required minimum. These are not large margins.

Based on such considerations, PCG has tried to identify the minimum staffing required to operate API efficiently, both in terms of its administrative functions, as well as in its delivery of effective treatment and inpatient care. It should be noted that some of the assumptions here are optimistic in regards to the impacts of staff reductions on service delivery, but we have indicated where we believe those assumptions are optimistic, though nevertheless warranted by the evidence of their feasibility.

7.3. Revenue Assumptions

CURRENT FUNDING SOURCES

PCG examined documentation from CMS 2552 Medicare Cost Reports and other data items from API to understand the current funding streams at API. Currently, through a mixture of patient revenue, and other funding sources API is able to cover its costs. In order to model future funding, PCG assumes that a private operator of API would be able to maintain the current level of patient revenue generated and the State would continue to cover the rest through the General Fund and other miscellaneous sources. Therefore, PCG projected funding based on the level of revenue required to continue to cover the hospital's costs as if it were operating normally. To do so, FY15 funding was used as a baseline and trended forward for a five-year period. Assuming costs increased by an inflation factor of 1.0298⁵⁰ annually, the required funding would likewise increase by the same amount. The table below shows the various revenue streams currently present and their proportion to total funding.

Table 7.3.1: Revenue and Funding at API⁵¹

	Source	Percentage	Five Year Amount	Average Annual Amount
State Funding	Medicaid	11.6%	\$20,997,854	\$4,199,570
	DSH	44.4%	\$80,581,509	\$16,116,301
	Other Inter Agency Receipts	1.6%	\$2,961,236	\$592,247
	State General Fund	24.5%	\$44,454,646*	\$8,890,929
Other Funding	VA	1.1%	\$1,974,157	\$394,831
	Medicare	9.3%	\$16,870,071	\$3,374,014
	Third Party Insurance	6.5%	\$11,844,943	\$2,368,988
	Self-Pay	0.2%	\$358,938	\$71,787
	Tele-behavioral Health	0.7%	\$1,346,016	\$269,203
	Other Program Receipts	0.1%	\$179,469	\$35,893
	Total Funding	100.0%	\$181,568,839	\$36,313,767
	State Share	53.5%	\$97,287,580	\$19,457,516

*Includes \$2,100,000 in IT Upgrades

Understanding that the legislature is interested in the cost-saving potential of privatization, PCG broke out the State's obligation in meeting the financial needs of operating the hospital. To calculate the State's share, PCG considered 50% of Medicaid and DSH as the State's contribution based on Alaska's Federal Medical Assistance Percentage (FMAP). PCG estimated the State's share of other Inter-Agency Receipts at 69% percent, as it is a mixture of Medicaid and Non-Medicaid sources. Lastly, all other general funds were included at 100%. As seen above in Table 7.3.1, the State is essentially responsible for providing 53% percent of funding after any form of federal reimbursement.

When comparing the cost of each privatization option to the expected funding, PCG transferred all savings or additional costs to the State's share. It is assumed that under all privatization options, patient revenue from federal and third party sources remains a constant regardless of the operational costs. Likewise, the State would benefit from continuing to maximize Medicaid and DSH payments, as these programs are eligible to receive federal match funds. Therefore, this model assumes that all additional costs or savings would be paid from or credited to the State's General Fund.

⁵⁰ Bureau of Labor Statistics, Consumer Price Index, 2016

⁵¹ Alaska Psychiatric Institute, FY15 CMS 2552 Cost Reports, Supporting Documentation 2015 API Budget and Expenditures

ANTICIPATED CHANGES

For the majority of the funding sources, PCG maintained the current level of funding. Our various privatization options assume that a private contractor would continue to bill state, federal and third party sources to generate revenue. With the recent Medicaid expansion in Alaska, PCG slightly increased the amount of revenue generated. A 2016 report by the Kaiser Foundation suggests that states who expanded Medicaid generally saw a 3.4% increase in Medicaid utilization⁵². PCG applied this to API's projected revenue. However, since the Chillkat unit is the only unit able to bill Medicaid, the projected increase to 11.7% of total funding does not have a large net effect. Outside of Medicaid, other revenue sources remain constant. This also assumes the DSH funding remains intact, which accounts for a substantial portion of overall funding. For Year One, PCG also reduced the State's overall operating budget by \$391,584. This accounts for the recent changes to the State's benefit structure that now requires higher employee contributions. PCG modeled this decrease to be four percent 4% of employee benefit costs.

7.4. Cost Assumptions

CAPITAL COSTS

A capital asset is an asset that has an expected life of more than one year that is not bought and sold during the normal course of business.⁵³ In the case of API, capital assets include land, facilities, and equipment, among other items. Especially in times when public revenues are scarce, it is incumbent upon all governmental entities to stretch the useful life of its capital assets as far as possible. When in need of cash, organizations can liquidate their capital assets, which produces immediate cash.

Liquidating capital assets, or the sale of those assets, is the simplest approach to transferring responsibility for deferred maintenance, on-going maintenance, and repair of the physical plant and land. A sale would provide the state with an infusion of cash that can be used to retire debts or, as in the case of other states, establish a fund for needy populations or services, or any other action the state deems appropriate.

If there is to be no sale of assets—a condition of the feasibility study—the question then becomes how the state could ensure appropriate updating and maintenance of the facility and other capital assets if those assets were leased or managed by a private entity. PCG's literature review about public and private capital asset management revealed that the most effective way to manage API assets requires a capital asset management plan. If one is in place, PCG recommends updating this annually.

A plan will help ensure that asset management strategies are driven by the goals of the entity and develop clear managerial responsibilities for asset management. In short, a comprehensive strategic asset management plan is needed for proper management of assets.⁵⁴ If the state were to consider privatization of capital assets, it would need to include strong language in its leasing agreement that the private entity must ensure proper maintenance of the facility and other capital assets. This will require the state to determine what a proper level of maintenance would be for the facility and other capital assets. Steps must include:

- Develop or update a comprehensive asset management plan;
- Develop specific measures related to asset planning outcomes; and,
- Insert asset management expectations, goals, and measures in the leasing option

⁵² The Henry J. Kaiser Family Foundation, "The Effects of Medicaid Expansion Under the ACA" 2016

⁵³ Wall Street Words: An A to Z Guide to Investment Terms for Today's Investor by David L. Scott. Copyright © 2003 by Houghton Mifflin Company.

⁵⁴ Harris, Dr. Robert. Public sector asset management: a brief history. By RAMIDUS CONSULTING LIMITED, May 2010. <http://www.ramidus.co.uk/papers/publicsectorassetman.pdf>

Using data from the FY15 Medicare Cost Report, PCG modeled API's capital costs at \$17,773. In the various privatization options, PCG trended this amount forward for a five-year period using an inflation factor of 1.0298. PCG found no reason to expect these costs to substantially increase or decrease under private direction and that capital expenditures would remain relatively proportionate in coming years. However, within the four scenarios there are differences around which party would be required to pay for any capital related expenses: the State or the private contractor. Under Option 1: Full Privatization, and Option 2: Joint Operating Agreement, maintenance of capital assets would be included under the scope of the contract, and therefore the costs would be overtaken by the incoming contractor. In Option 3: State Management with New Efficiencies, and Option 4: Component Outsourcing, these costs would continue to be covered by the State.

PROFIT AND MARGINS

In all scenarios related to full or partial privatization, it is assumed that the incoming contractor would expect to make a profit in addition to having its costs covered. Therefore, PCG found it necessary to predict the expected profit margin the State would be responsible for paying. In doing so, PCG estimated margins based on two organization types: a for-profit provider and a not-for-profit provider. This provides the State with a series of options to weigh when determining a vendor, as well as creating parameters for estimating likely expenditures related to profit.

The expected margin for a for-profit contractor is eight percent (8%). This estimate is based on reporting from South Florida State Hospital, a privatized state hospital, as well as annual financial statements from another for-profit hospital provider, Universal Health Systems. These profit expectations are also commonly found in Request for Proposal responses to similar privatization efforts in other states.

The expected margin for an incoming not-for-profit contract would be four percent (4%), based on hospital benchmarks created by Becker's Hospital Review. To estimate costs related to margin for both organizational types, PCG applied the expected margin to the total estimated cost of services being contracted.

SALARY AND BENEFIT BENCHMARKS

As an initial step in modeling the salary and benefit costs of a private entity operating API, PCG analyzed data prepared by API accounting staff in the 2015 Hours Report and 2015 Dollars Report. With these two data items, PCG was able to calculate the number of FTEs in each respective cost center and determine cost per FTE. The cost per FTE was broken out to estimate costs related to wages including regular salary, leave, overtime, pay differentials as well as employee benefits.⁵⁵

For the purpose of this analysis, PCG classified all wages paid in regular salary, leave, overtime and pay differentials as total salary. To estimate salaries for private staffing, PCG took API's current total salaries and increased them by 13.7%⁵⁶ to model private salaries. This estimate is based on data from the 2014 BLS CPS Survey, which found that the private sector typically pays 13.7% more in salaries compared to their public counterparts. Therefore, API personnel under a private company would generally receive higher salaries than they currently make. PCG also noted that a private company would likely define full-time differently than the State: in which overtime would be applied beyond 40 hours rather than 37.5 hours per week. This would have an effect on overtime costs, as a private employee would have a higher ceiling for overtime eligibility. This issue is expanded on in the following section.

While salaries would likely increase, PCG's model projects a reduction in overall compensation. A current analysis performed by the University of Alaska Anchorage's Institute of Social and Economic Research (ISER) that was prepared for the Alaska Department of Administration found that employee benefits contribute to a substantially greater portion of total compensation in the public sector than in the private. Currently, an average

⁵⁵ Alaska Psychiatric Institute, "2015 Dollars Report by Department", "2015 Hours Report by Department"

⁵⁶ Bureau of Labor Statistics, Current Population Survey (BLS CPS) 2014

of 36% of total compensation at API is paid through employee benefits. For the purposes of this report, PCG is including insurance (health, life, short-term disability, and long-term disability), retirement and savings (defined benefits, defined contributions) and legally required benefits (Social Security, Medicare, State and Federal Unemployment, Workers Compensation Insurance) in our definition of API staff employee benefits.

Based on the ISER report, PCG estimated private (non-public sector) benefits to be 22% of total compensation. This estimate is in line with findings from PCG's previous privatization work which found that benefits were within the 20% range at other privatized state hospitals. Using PCG-estimated private salary and benefit costs per FTE, the table below shows the current total compensation per FTE at API currently, compared to what the same staff would cost with the estimated private salary and benefits.

Table 7.4.1. Average Total Compensation per FTE

	FY15 API (Public)	Private API	% Change
Admin, Indirect	\$94,747	\$79,484	(19%)
Nursing, Mental Health Worker	\$92,212	\$79,751	(16%)
Direct-Care, Other Medical	\$134,738	\$130,473	(3%)
Rehabilitation	\$106,341	\$94,347	(13%)
Psychology, Psychiatry	\$208,671	\$206,052	(1%)
Social Work, Counseling	\$107,126	\$99,246	(8%)

These findings suggest that while salary costs would be higher to the State with private staffing, the large reduction in spending on employee benefits would cause considerable savings in terms of total compensation. As mentioned later in this report, PCG was made aware of coming changes to the State's employee benefit structure that will reduce cost through requiring higher employee compensation. PCG included these potential savings in our five-year cost projections for each applicable privatization scenario. Furthermore, it is important to note that not all staff would see an increase in salaries due to high levels of overtime pay that the facility has historically paid.

PNAs, in particular, would receive less compensation through salaries under a private entity. This is because a large proportion of a PNA's current salary costs under the State are composed of overtime pay, inflating total compensation. Through more effective scheduling and different criteria for determining overtime eligibility, a private contractor would contain costs by implementing practices to reduce overtime hours for PNAs. Therefore, the 13.7% salary increase would be applied to a lower starting point than currently reported for PNAs at API. The effects of overtime are expanded on in the following section.

EFFECTS OF OVERTIME

In recent years, overtime pay has been an ever-increasing cost driver at API. In FY15 alone, a total of 31,914 hours, of overtime were paid, totaling \$1,148,407⁵⁷. Through the stakeholder interviews and data from API, PCG found that the bulk of overtime hours are generated by nursing department staff. This reliance on overtime is largely explained by the acute nature of treatment being delivered at API and the unpredictability involved in needing to augment direct care staff for high-acuity patients with difficult behaviors. API often serves Alaskan patients with the highest acuity. With limited bed space, census pressure at API is high, and ALOS is much lower relative to peer facilities. As a result, nursing department staff (generally PNAs) are often required to stay over their scheduled hours to observe and supervise high need patients. PCG was informed that certain patients often require a 1:1 or even 2:1 nursing department staff to patient ratio, depending on exhibited and documented behaviors. While high levels of overtime are an inevitable feature of acute psychiatric care, PCG also identified a

⁵⁷ Alaska Psychiatric Institute, "2015 Dollars Report by Department", "2015 Hours Report by Department"

number of staffing practices that could be eliminated or altered to reduce the use of overtime without negatively affecting service delivery. For example, scheduled overlap in RN nursing shifts has been suggested as a contributing cause of high overtime costs without demonstrated benefit to service delivery. API is currently reviewing the practice and determining the feasibility of implementing 12-hour shifts for RNs, similar to the schedules worked by API's PNAs. This will help limit and reduce the amount of time spent performing face to face shift change reports.

Another concern raised by stakeholders was the use of overtime in hospital administrative positions and the communications center. Since these positions are not involved with direct care, it is unclear why overtime in these areas is occurring. PCG regards this type of overtime as an inefficiency that would be minimized under private management.

In modeling our scenarios regarding privatization, PCG determined that a private contractor would be able to reduce the amount spent of overtime, simply by reclassifying what is considered an FTE. Currently, the State pays overtime to any employee working over 37.5 hours per week. This is a contractual requirement in place with the collective bargaining units that represent current API employees. Under a private contractor, overtime eligibility would begin once an employee exceeded 40 hours per week. This would reduce overtime costs by increasing the threshold for overtime eligibility. In determining the costs of our various privatization scenarios, PCG applied the assumption that a private contractor would only pay overtime rates for employees who work over 40 hours in a given week, effectively reducing the amount of overtime being paid.

LEGAL COSTS

Given the nature of providing services in an inpatient psychiatric hospital, it is likely that a potential contractor would incur legal costs related to patient and staff safety as well as other liabilities that are not currently reflected in API's budget, since assumed by the Department of Law. A contractor would likely expect these costs to be covered as a provision in the agreement with the State. To estimate the potential legal fees a contractor may assume by running API, PCG used a benchmark established by ALM Legal Intelligence. For employers similar in size to API, ALM estimates legal costs to be 0.369% of revenues⁵⁸. Given the various privatization scenarios that PCG is presenting, and the variable definition of privatization for each, PCG based likely legal costs as 0.369% of the total cost of contracted services. This allows for legal expenses to scale proportionately based on the scope of the contract for each privatization option.

ADMINISTRATIVE COSTS

In determining feasibility of privatization, PCG has aimed to gather all relevant information regarding certain inefficiencies at API, including stakeholder interviews as well as comparisons of API to small and large peer facilities. A recurring trend seems to be that administrative costs are relatively high at API in comparison to other hospitals. In some cases, these inefficiencies are due to high staffing. In other cases, there is an assumption that a private entity could create new efficiencies by simply having administrative functions absorbed into pre-existing corporate functions and technical infrastructure. Based on feedback as well as reasonable assumptions about organizational functions under a private company, PCG noted the following areas as having opportunities for increased efficiencies: IT functions (EMR), quality improvement staff, the communication center, and nursing administration.

As mentioned in Section 6.2, costs related to the EMR department have increased significantly in the past five years, particularly non-salary costs related to maintenance of the current system. A private contractor would likely enter API with its own electronic medical record (EMR) system. This would save the State the cost of additional investment to upgrade the current Meditech system. Furthermore, as a provider with existing EMR staff, there would not be a need to host this department within the hospital. Rather, the contractor could use external

⁵⁸ ALM Legal Intelligence, "Law Department Metrics Benchmarking Survey" 2014

resources resulting in lower costs. For Option 1: Full Privatization and Option 2: Joint Operating Agreement, this leads to immediate savings on staffing expenditures. Currently, API spends \$380,703 for 2.85 FTEs related to EMR. If IT support for the EMR system remained under State control, API would continue to need to staff this department. Under Option 3: State Management with New Efficiencies, PCG modeled API running the EMR cost center with a different mix of staff. In addition, the staffing practices at API for EMR are unusual, in that higher-cost nursing staff are used to staff the function, along with an IT Coordinator. Typically, EMR staff is composed mainly of IT professionals. Staffing this function in accordance with standard practice could yield an immediate savings of \$50,123 annually for the same number of FTEs.

Much like IT functions, a private contractor would not need to support quality improvement (QI) staff within the hospital, since that function would most likely be distributed across the enterprise. Assuming an incoming contractor makes use of its existing QI infrastructure, this function would be another opportunity for savings. Currently, API spends \$292,330 on 2.46 FTEs in this department.

The communication center is another area in which the State could generate cost savings by transferring to a private contractor. As it currently functions, the communication center employs 6 FTEs at an expense of \$530,634⁵⁹. This is a function that must remain staffed at all times. However, frequent shift overlap and mandatory overtime has resulted in significant inflation of costs under current management. As noted in API's Communication Center Analysis from July 2016, PNAs are often brought into the communication center to cover breaks. This is problematic since it reduces direct care staff on the floor and is more costly to the State. Furthermore, the unit cost of operating the communication center with State employees is much higher than that of a private company. PCG analyzed the communication center and found that it was feasible for API to secure staffing from a private firm at a unit cost of \$25.00 an hour compared to the \$45.35 currently spent. Furthermore, the number of FTEs required to run a privatized communication center is much lower, since a contractor would have a larger labor pool to draw on to ensure appropriate shift coverage without use of overtime.

As noted in Section 6.2, nursing administration is another administrative function that has been historically high for the State. Numerous stakeholders have noted that it is unclear what exactly is driving these costs. Nursing administration at API is fairly robust compared to peer hospitals, with almost 30% more nursing administrators than hospitals of similar size and function. Furthermore, much of the time spent by nursing administration is spent reaching out to full-time and temporary nursing department staff in order to relieve coverage gaps by seeking RNs and PNAs willing to work overtime. PCG's privatization scenarios assumed that a private contractor would reduce the amount of hours in nursing administration and transfer some of the resources currently used for administration to a direct care role.

EXPECTED COST SAVINGS

There are various cost savings assumptions built into PCG's four privatization options. Beginning in FY17, the State is implementing changes to public employee benefits. These changes will increase the contribution amount paid by the employee. Effectively, this will reduce the cost of benefits to the State by passing a portion of total cost to the employee. While data to determine the true savings from these changes is so far unavailable, PCG estimated a reduction of four percent (4%) to model benefit costs under this new structure. PCG based our reduction on the decrease in total funding budgeted for benefits by the Alaska Office of Management and Budget for the period of FY15 to FY17⁶⁰.

When assessing the feasibility of privatization, PCG modeled costs and expected funding on an "as-is" basis, using current expenditures and revenue and trending them forward using an inflation factor of 1.0298. Costs for the various privatization scenarios differ as some models assume private staffing, public staffing, or a mixture of the two. Likewise, certain options involving privatization include extra costs related to a potential contractor's expected profit, legal fees, and contract administration. PCG assumes that whatever savings are produced by

⁵⁹ Alaska Psychiatric Institute, "API Communication Center Analysis, July 2016"

⁶⁰ State of Alaska, Office of Management and Budget, FY15 and FY17 Operating Budgets

each scenario will be applied directly to the General Fund and that the state would continue to maximize all possible patient revenue and federal match in direct benefit to the General Fund. PCG also modeled each privatization option with alternate staffing. As established through our peer facility comparison and what is known about previous privatization attempts, it is likely that an incoming contractor would reduce costs through a reduction in staff. However, in order to minimize the adverse effects of staff reductions, PCG created the Recommended Staffing Scenario to model reduced yet adequate staffing. These reductions could generate additional cost savings to the State.

7.5. Other Transition Costs

IT ASSUMPTIONS

PCG was informed that API's electronic medical record (EMR) system, Meditech, is in need of substantial upgrades. The current version of Meditech in use at API suffers from limitations that pose future security risks to the State as well as restricting the useful dissemination of data for care coordination across the behavioral health system. In its current state, Meditech does not meet the State's security standards or industry standards. Furthermore, there is a lack of compatibility with health information exchanges including pharmacy and medication management systems. This potentially contributes to increased rates of recidivism, as community providers are unable to determine whether patients discharged from API are accessing services or receiving medication. These deficiencies will need to be addressed by the State to minimize security liability, ensure continuity of monitoring and improve coordination with community providers.

In 2016, DBH was quoted a cost of \$2.1 million to upgrade the current system. This cost was factored into PCG's cost models as a necessary expenditure. Regardless of the privatization scenario, the State would have to set aside the necessary funding to perform the upgrade. In scenarios where a private contractor was to assume EMR responsibilities and use their own EMR system, the allotted funding could be considered a cost savings to the State, since the expensive upgrades would no longer be necessary. In scenarios where the State retains control of the EMR systems, the \$2.1 million is included in the overall cost to State.

As previously mentioned, further cost savings can be found through a reduced need for staffing related to EMR under privatization. A private entity would have EMR dedicated staff included in its corporate structure. Therefore, there would no longer be a need for in-house IT staff, which would increase savings.

RETIREMENT COSTS

Any transition in staff from the public sector to the private sector could result in additional costs related to liabilities to the retirement fund financing Alaska's Public Employee Retirement System (PERS). Currently, the State retirement plan is funded based on the assumption that, on average, members will work 4 years beyond normal retirement eligibility. Their benefit is calculated to be fully funded at that time. However, if a member is terminated from PERS coverage, this behavior changes, and they will draw the retirement benefit at first eligibility. Additional costs to the retirement fund arise due to these changes in retirement behavior by the removed defined benefit employees. The change to retiring right at normal retirement means the benefit is not yet fully funded, and benefits will be paid for four more years than expected.

Of course, these costs cannot be estimated accurately without specific information on each individual defined benefit employee and their relationship to the normal retirement date. Furthermore, there may be additional liabilities to the fund, which depend on whether terminations at API are part of wider proportion of layoffs within the population of public employees during the same annual period. Whether these costs apply, and how they interact with the basic liability incurred through API privatization would require a full actuarial study to determine the cost.

Without the supporting data for these types of calculations, PCG was not able to estimate retirement costs based on an approach approximating the methods of an official "termination study." However, we were able to obtain

from Alaska's Department of Administration the results of a previous study of a hospital of similar scale, involving more than 200 employees. That termination study, conducted in 1997, involved a total termination liability of \$2,129,884. While it is important to note the limitations in directly applying the same results in potentially disparate cases, PCG believes this figure offers an appropriate sense of scale for an estimate of liability. Given that the base study was performed twenty years ago, it is reasonable to expect that costs would have increased significantly since that time. However, during this period, there have been a number of structural changes made to the State's retirement plans, and a larger proportion of employees have lower-tier, lower-value plans than would have been seen in 1997. These discontinuities cancel each other out, at least in part.

Barring the possibility of a more fine-grained approach, PCG opted for a rough, aggregate approach that designated minimum State liability at \$2 million under a full privatization option. For the outsourcing options that involve smaller subsets of hospital personnel, PCG employed a proration methodology that estimated liability for particular options, based on the proportion of the hospital's FTEs affected. Dividing the \$2 million per FTE yielded a retirement cost per FTE, which could be applied to each option by multiplying the cost per FTE by the total number of FTEs impacted by the proposed type of privatization.

TRANSITION COSTS AND CONTRACT MONITORING

PCG has also estimated additional privatization costs to the State in the form of procurement costs and ongoing contract monitoring costs. According to contract monitoring best practices, these costs should be allocated to perform the following activities:

- The initial procurement of services, including vetting prospective clients
- Training DHSS or DBH staff on effective contract monitoring principles
- Developing written policies and procedures to serve as a guide to agency personnel
- Developing contingency plans in the event of a failure to execute by the contractor
- Developing clear performance measures and expectations for an incoming contractor
- Developing a contract administration plan with routine status reports for the duration of the contract
- Archiving and maintaining all relevant contract files and documentation
- Creating contractually binding payment incentives related to satisfactory performance, and consequences related to poor performance
- Developing requirements for periodic programmatic reports from the contractor related to payment incentives
- Routine and random on-site monitoring by DHSS or DBH staff
- Developing benchmarks to measure consumer satisfaction with the services provided by a contractor
- Developing agreements with a contractor to have full access and ability to audit records

Virtually every authority on privatization agrees that the success or failure of the contracting process depends on the agency's ability to provide adequate contract monitoring. Some experts, in fact, consider "monitoring, along with principal-agent problems, to be the most important factors in contracting decisions."⁶¹ However, monitoring entails additional costs that are not always simple to capture or predict, *especially when service quality rather than product quality is under evaluation*. The amount of funding necessary to ensure appropriate monitoring is largely dependent on the complexity and type of service contracted out, as well as the potential risks incurred from inadequate performance and the costs of remediation. In the case of inpatient psychiatric care, performance risks are substantial, and these risks are only amplified by the State's heavy reliance on API for psychiatric beds.

While monitoring costs are sometimes explicit, as in instances in which outside auditors are hired to monitor contracts, costs are also incurred even when monitoring is done internally with existing staff resources. Cost calculations in the latter case are more complicated, because, for example, employee time must be allocated

⁶¹ Marvel, Mary K., and Howard P. Marvel. "Outsourcing Oversight: A Comparison of Monitoring for In-House and Contracted Services." *Public Administration Review* 67, no. 3 (2007).

between monitoring and other tasks. Even when additional costs are implicit, they can be substantial, and are too often ignored. Despite the elusiveness of measuring contract procurement and monitoring costs, a number of studies have suggested that these costs are frequently as high as 20% of the total cost of the contract.⁶² For example, one Louisiana case study found that contract management raised costs 20% above the in-house level, with the difference being almost completely due to the additional costs from contract preparation and supervision of the contracted work.⁶³ Many scholars use a figure of 20% of the contracting budget as a routine estimate.⁶⁴

Although PCG believes that the use of a 20% figure for estimating contract monitoring costs is defensible, we have opted for a figure of 15%, noting that not every study conducted on the issue has found monitoring costs to be as high as 20%. For instance, in an analysis of contracting in California, found that administrative and monitoring costs of contracting represented approximately 14% of the contract amount.⁶⁵ It is also true that monitoring expenses can be reduced as the parties evolve a relationship of trust, as a number of studies have illustrated.⁶⁶ In projecting ongoing monitoring costs over a five-year period, we decided it was more reasonable to use a 15% estimate. Rather than providing a detailed cost estimate of particular requirements and activities associated with contract monitoring, we calculated these costs as a percentage of a contractor's projected costs, adding this percentage as an additional line item in summing the total cost of privatization for each option.

⁶² See Pack, Janet Rothenberg. "Privatization and cost reduction." *Policy Sciences* 22, no. 1 (1989): 1-25; Prager, Jonas. 1994. "Contracting out government services: Lessons from the private sector." *Public Administration Review*. Vol. 54, No. 2, pp. 176-84.; and Sclar, Elliot 2000. *You Don't Always Get What You Pay For: The Economics of Privatization*. Ithaca, N.Y.: Cornell University Press. These studies are among those most frequently cited.

⁶³ Wilmot, C. G., Deis, D.R., Schneider, H., & Coates, Jr., C. 1999. In-house versus consultant design costs in department of transportation. *Transportation Research Record No. 1654*, 153-160.

⁶⁴ Marvel, Mary K., and Howard P. Marvel. "Outsourcing Oversight: A Comparison of Monitoring for In-House and Contracted Services." *Public Administration Review* 67, no. 3 (2007).

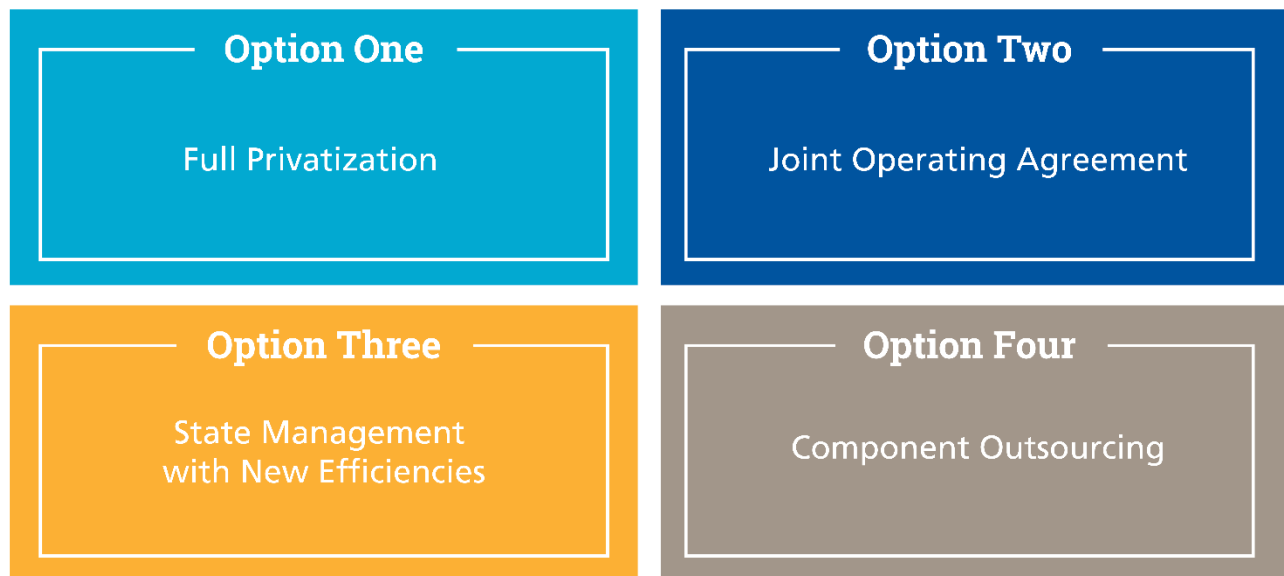
⁶⁵ Teal, R. F. (1991). "Issues Raised by Competitive Contracting of Bus Transit Service in the USA." *Transportation Planning and Technology*, 15(2-4): 391-403.

⁶⁶ See Cooper, P. (2003). *Governing by Contract*. Washington, DC: CQ Press; Cohen, S., & Eimicke, W. (2008). *The Responsible Contract Manager*. Washington, DC: Georgetown University Press; Fernandez, S. (2009). "Understanding Contracting Performance: An Empirical Analysis." *Administration & Society*, 41 (1): 67-100; LeRoux, K. (Ed.). (2007). *Service Contracting*. Washington, DC: International City/County Management Association.

8.0. COST-BENEFIT ANALYSIS

8.1. Overview

PCG has modeled four privatization options for API, ranging along a spectrum from full privatization of API to the State retaining API's current functions. Below is an overview of each of the four options, which were analyzed in terms of the feasibility of producing financial savings and potential for improved service delivery and quality of care, as well as community impacts.



PRIVATIZATION OPTIONS

Option 1: Full Privatization

Full Privatization involves a private contractor assuming all operational aspects of API. The State would retain ownership of API's land and capital assets, and would either lease the facility to the contractor or hire the private provider as a property manager. In this option, the State's responsibilities in managing API would be restricted to its role as a contract administrator, providing oversight and monitoring the contractor's performance.

Privatization efforts in Florida serve as the best example for this model, and provides a case for full privatization as a feasible option. However, it should be noted that implementing this option presents the highest contract administration cost to the State which could offset any savings found through private staffing.

Option 2: Joint Operating Agreement

A **Joint Operating Agreement** is a variation of the full privatization option, as it does not differ substantially from the first option in estimated financial impact or responsibility for service delivery. Instead it sets up privatization on a legal basis distinct from full privatization, in which privatization would be achieved by creating a new legal entity through agreement between a private provider and DHSS, implemented either as a public corporation similar to AMHTA, or a 501 (C)(3) private, non-profit corporation. Establishing a joint operating agreement model for API would allow the State organizational flexibility and greater involvement in day-to-day operations while still maintaining low staffing costs through private employees. However, the agreement would potentially divide

management authority, to the detriment of efficient operations. Responsibilities between partners would need to be considered carefully to ensure effective management.

Option 3: State Management with New Efficiencies

This third option is not a privatization option, but provides an alternative to privatization. This option considers the impact of implementing the changes in staffing and business and service delivery process that would likely occur under a private operator, but assuming continued State management. This option explores what sorts of efficiencies can be achieved within the present management structure, without having to take on the risks involved in the contracting process. This model would take a similar approach to the other models in addressing staffing inefficiencies and reducing overtime to achieve cost savings. Additionally, this option would eliminate the costs and risks associated with privatization, as the State continues to operate and manage Alaska's only psychiatric hospital. Retaining public control comes with its own risks and limitations, however. Namely, API would have fewer options to reduce some of its current high administrative costs, and would be unable to take advantage of some of the economies of scale available to a private healthcare entity.

Option 4: Component Outsourcing

Component Outsourcing, analyzes individual components of the hospital that could be outsourced without diffusing administrative responsibilities or fragmenting service delivery or hospital operations. In each of the Component Outsourcing models developed by PCG, the State would retain its responsibilities as the hospital administrator, but would contract out some or all of the facility's service delivery and operational functions. Noting that some functions, such as food services, are already contracted out to private vendors, PCG identified five distinct hospital components for further analysis:

Option 4a: Communication Center Outsourcing

This option considers the impact of privatizing the Communications Center, which serves as API's front desk, providing security and reception functions. This unit must be staffed at all times. Under this option, PCG examined the cost implications of a private security firm running the communication center.

Option 4b. Facility and Material Management Outsourcing

PCG considers the outsourcing of various operational aspects of API to a provide contractor. This option models the cost of a private company performing all maintenance and custodial duties at API. While all direct care staff would be retained under State management in this option, staffing for facility operations, central services and supplies, and environmental services would be privatized. This option aims to identify areas for cost savings by privatizing staff that does not provide direct care. Therefore, this option is unlikely to create impediments to service delivery or quality of care.

Option 4c: Psychiatric and Medical Staff Outsourcing

PCG considers the implications of privatizing the psychiatric and medical staff at API. Maintaining necessary psychiatric staff has been a long-standing issue at API. This option weighs the potential advantages of contracting out these services to a private contractor, along with the limited medical services provided at API. One example in which this approach to privatization has occurred is New Hampshire, where the state's psychiatric hospital is staffed by psychiatrists from Dartmouth University.

Option 4d: Nursing Staff Outsourcing

Under this option, Nursing Administration, Nursing Clerks, Psychiatric Nursing Assistants and Registered Nursing staff would be contracted out. This could potentially cut nursing costs, particularly for PNAs, through lowering overall compensation levels and permitting more effective implementation of optimal scheduling and overtime use policies. This is an approach to privatization evident in the State of Kentucky, which currently contracts out most of the nursing services within its state hospital system.

Option 4e: Comprehensive Outsourcing

Under this option, all direct care, including nursing, psychology, psychiatric, rehabilitative and medical services would be contracted out. Likewise, select operational departments of API would be assumed by the incoming contractor, including the communication center, facility operations, central services and supply, and environmental services. Essentially, this option leaves the State with a limited role as hospital administrator. This option would apply the advantages of the other component options more generally, allowing the state to retain operational responsibility for API while taking advantage of potential cost savings through reduced personnel costs, improved efficiency in service delivery and reductions in compensation costs.

STAFFING SCENARIOS AND SUMMARY OF FINDINGS

For each of the Privatization Options discussed above, PCG modeled the Baseline FY15 and Recommended Staffing Scenarios for not-for-profit and for-profit hospital vendors. Below are descriptions of the staffing scenarios utilized.

FY15 Baseline Staffing Scenario

Under the FY15 baseline staffing scenario, PCG modeled the cost of operating API at the current FTE count for all four privatization options. This allows for a comparison of costs based solely on the transition from public to private compensation. This is not a recommended staffing situation, but serves as a useful reference point when reviewing the options. The following table shows the expected five-year cost for each respective option under a not-for-profit vendor, with the exception of Option 3: State Management with New Efficiencies.

Table 8.1.1: Cost Comparison: Not-For-Profit Margin (FY15 Baseline Staffing)

	Five Year Expected Funding	Five Year Cost	Cost Over / Under Expected Funding	Percentage Increase / Decrease
1. Full Privatization	\$181,568,839	\$198,210,530	\$16,641,691	9.2%
2. Joint Operating Agreement	\$181,568,839	\$198,210,530	\$16,641,691	9.2%
3. State Management	\$181,568,839	\$181,568,839	-	0.0%
4. Component Outsourcing				
4a. Comm. Center	\$3,538,700	\$3,080,041	-\$458,659	-13.0%
4b. Facility & Material Mgmt.	\$10,460,429	\$9,233,045	-\$1,227,384	-11.7%
4c. Psychiatry & Medical Svcs.	\$22,127,758	\$26,293,222	\$4,165,464	18.8%
4d. Nursing	\$76,180,507	\$80,413,385	\$4,232,878	5.6%
4e. Comprehensive	\$131,173,383	\$142,297,800	\$11,124,418	8.5%

As illustrated above, Option 1: Full Privatization and Option 2: Joint Operating Agreement would not generate any savings to the State as their five-year costs exceed the five-year estimated funding. Therefore, basing the cost comparisons on the FY15 Baseline staffing FTE count of 250.21, none of the options that privatize API in its entirety would generate any savings to the State under a not-for-profit contractor. Option 3: State Management with New Efficiencies is cost-neutral, as no changes have been implemented under the FY15 Baseline Staffing Scenario. When privatizing sub-components of API, Options 4a: Communication Center Outsourcing and 4b: Facility and Material Management Outsourcing, do generate a reduction in expenditures for their respective cost centers. These savings are due to a decrease in compensation for the affected workers under a private vendor.

The following table shows expected five year costs under a for-profit contractor which includes a higher profit margin.

Table 8.1.2: Cost Comparison: For-Profit Margin (FY15 Baseline Staffing)

	Five Year Expected Funding	Five Year Cost	Cost Over / Under Expected Funding	Percentage Increase / Decrease
1. Full Privatization	\$181,568,839	\$205,730,408	\$24,161,569	13.3%
2. Joint Operating Agreement	\$181,568,839	\$205,730,408	\$24,161,569	13.3%
3. State Management	\$181,568,839	\$181,568,839	-	0.0%
4. Component Outsourcing				
4a. Comm. Center	\$3,538,700	\$3,196,389	\$(342,311)	-9.7%
4b. Facility & Material Mgmt.	\$10,460,429	\$9,581,084	\$(879,345)	-8.4%
4c. Psychiatry & Medical Svcs.	\$22,127,758	\$27,299,214	\$5,171,456	23.4%
4d. Nursing	\$76,180,507	\$83,460,330	\$7,279,823	9.6%
4e. Comprehensive	\$131,173,383	\$147,700,384	\$16,527,001	12.6%

As expected, a for-profit contractor would have increased cost due to higher expected profit. Therefore, Option 1: Full Privatization and Option 2: Joint Operating Agreement continue to be infeasible if API was to keep staff at approximately current (FY15 through FY17) levels. There is no cost effect on Option 3, since there would be no additional cost related to profit margin under state management. Outsourcing of the Option 4a: Communication Center Outsourcing and Option 4b Facility and Material Management Outsourcing continue to produce savings, although at a smaller proportion. Detailed cost analyses are provided for each individual option in the following sections.

The overall conclusion of this baseline analysis is that some reduction in staffed hours will need to occur if the State is to realize a savings while allowing a private provider to retain margins. Therefore, PCG modeled the fiscal impact of each privatization option after a reduction in overall FTEs.

Recommended Staffing Scenario

The Recommended Staffing Scenario shows the fiscal impact of privatization after a reduction of staff. Stakeholder comment, peer hospital comparisons and staffing standards in the research literature were used as a basis for developing PCG's Recommended Staffing Scenario. In determining staffing levels, PCG did not make broad cuts to all staffing categories as reported in the FY15 baseline. Rather, a targeted approach was taken based on identified areas of opportunity for improving operational efficiency. However, between the different options, there is some fluctuation in FTE counts. Due to differences in existing and assumed resources between the State and a private entity, the reductions throughout each scenario are not the same, and therefore the personnel structure varies between the models. FTE counts are provided in each option's individual analysis in the following sections.

The following table provides the expected five-year cost of each option under a not-for-profit contractor:

Table 8.1.3: Cost Comparison: Not-For-Profit Margin (Recommended Staffing)

	Five Year Expected Funding	Five Year Cost	Cost Over / Under Expected Funding	Percentage Increase / Decrease
1. Full Privatization	\$181,568,839	\$183,525,628	\$1,956,789	1.1%
2. Join Operating Agreement	\$181,568,839	\$183,525,628	\$1,956,789	1.1%
3. State Management	\$181,568,839	\$168,504,311	-\$13,064,528	-7.2%
4. Component Outsourcing				
4a. Comm. Center	\$3,538,700	\$1,284,975	-\$2,253,726	-63.7%
4b. Facility & Material Mgmt.	\$10,460,429	\$9,233,045	-\$1,227,384	-11.7%
4c. Psychiatry & Medical Svcs.	\$22,127,758	\$26,293,222	\$4,165,464	18.8%
4d. Nursing	\$76,180,507	\$74,543,836	-\$1,636,670	-2.1%
4e. Comprehensive	\$131,173,383	\$134,036,457	\$2,863,075	2.2%

Even through a reduction in FTEs, Options 1 and 2 continue to generate new costs to the State. Therefore the full privatization is infeasible from a fiscal perspective. Option 3: State Management with New Efficiencies generates substantial savings, due to lower personnel expenditures. Outsourcing of the communication center would produce substantial savings, especially considering the relatively small number of employees affected. Option 4b: Facility and Material Management Outsourcing was not affected by the recommended staffing, and retains the current level of staffing. Lastly, modest savings could be found through the privatization of nursing staff under a not-for-profit vendor.

The following table illustrates each privatization option's expected five year total cost under a for-profit entity:

Table 8.1.4: Cost Comparison: For-Profit Margin (Recommended Staffing)

	Five Year Expected Funding	Five Year Cost	Cost Over / Under Expected Funding	Percentage Increase / Decrease
1. Full Privatization	\$181,568,839	\$190,482,698	\$8,913,860	4.9%
2. Join Operating Agreement	\$181,568,839	\$190,482,698	\$8,913,860	4.9%
3. State Management	\$181,568,839	\$168,504,311	-\$13,064,528	-7.2%
4. Component Outsourcing				
4a. Comm. Center	\$3,538,700	\$1,332,281	-\$2,206,419	-62.4%
4b. Facility & Material Mgmt.	\$10,460,429	\$9,581,084	-\$879,345	-8.4%
4c. Psychiatry & Medical Svcs.	\$22,127,758	\$27,299,214	\$5,171,456	23.4%
4d. Nursing	\$76,180,507	\$77,365,180	\$1,184,673	1.6%
4e. Comprehensive	\$131,173,383	\$139,121,508	\$7,948,126	6.1%

Under the Recommended Staffing Scenario, full privatization of API would not reduce costs under a for-profit contractor. Option 4a: Communication Center Outsourcing and Option 4b: Facility and Material Management Outsourcing continue to produce savings. Both of these options would appear to be an attractive option for a private vendor. All other component outsourcing options related to direct care staff are infeasible from a cost perspective, assuming margins typical of a for-profit vendor. Detailed cost analyses and staffing assumptions are provided further in this report under each option's respective section

8.2. Option 1: Full Privatization

Assumptions

Option 1: Full Privatization assumes that all duties and services would be managed by a private, not-for-profit or for-profit contractor. In this scenario the State would take on the role of contract administrator. The following assumptions influence the two staffing scenarios of Full Privatization:

- Under this option, the contractor would be responsible for all incurred capital costs and would manage the operation and maintenance of the physical plant.
- A range of margins are modeled and applied to the total cost of services: a 4% minimum margin, typical of a not-for-profit company, as well as an 8% margin more reflective of the expectations of a for-profit company.
- Private salaries are modeled to be 13.7% higher than current state salaries, with benefit costs constituting 22% of private total compensation.
- A private operator classifies an FTE as an employee working 40 hours instead of 37.5 hours per week, reducing overtime levels.
- The cost of worker's compensation is included in benefit cost estimates for both public and private insurance.
- Legal costs are benchmarked at 0.369% of the total cost for contracted services.
- Contract monitoring costs are estimated at 15% of total contract value.
- An incoming contractor would use its own EMR system, yielding a cost avoidance of \$2.1 million to the State in future IT investment relative to the baseline costs under State management.
- The State's termination liability is estimated at \$2 million since all 250.21 FTEs are being privatized under this option. The rationale and evidential support for these assumptions are discussed in detail in Section 7.0

Staffing Scenarios

The following FTE counts were used to estimate costs for Option 1: Full Privatization under the two staffing scenarios. Under this option, all FTEs at API would be privatized. While, all staff at API would be privatized, not all departments would experience a reduction in staff. **The table below illustrates the FTE counts for departments that experience a change in FTEs from the FY15 Baseline Staffing Scenario to the Recommended Staffing Scenario.** Bold values in the recommended staffing column indicate a change in FTE count.

Table 8.2.1: FTEs per Department under Option 1: Full Privatization

	Department	FY15 Baseline Staffing	Recommended Staffing
Administrative/Indirect	EMR	2.85	0.00
	Admin. & General	9.74	8.63
	Business Office	6.26	5.73
	Facility Operation	8.41	8.41
	Laundry & Linen	0.71	0.71
	Environmental Services.	11.03	11.03
	Nursing Admin.	10.17	8.47
	Central Svcs. & Supply	2.80	2.80
	Health Info Management	7.96	4.25
	Comm. Center	6.84	4.45
	Medical Director	0.00	0.45
	Quality Improvement	2.46	0.00
	Nursing Clerk	5.30	5.30
Nursing	Nursing PNA	82.19	76.91
	Nursing RN	44.95	42.07
Direct Care/ Other Medical	Pharmacy	2.82	2.82
	ASO	6.80	6.80
	Medical Services	2.68	2.68
Rehabilitation	Recreational Therapy	1.95	1.95
	Occupational Therapy	2.61	2.61
	Industrial Therapy	0.94	0.94
Psychology/Psychiatry	Psychology	6.41	5.40
	Psychiatry	9.80	9.80
	DJJ Psych Services	0.14	0.14
	Tele-psych	2.52	2.52
Social Work/Counseling	Social Services	10.01	9.37
	Peer Support	1.83	1.71
	TOTAL	250.21	225.99

There were numerous factors that informed the development of the Recommended Staffing Scenario. Under administrative and indirect care staff, certain FTEs are eliminated in the analysis, due to an assumed pre-existing corporate infrastructure that would be available to a private entity. For instance, PCG assumed that a private contractor would already have an electronic medical record (EMR) system in place and would not need to provide staff within the hospital or the costs of additional technology upgrades. Similarly, a contractor would already have quality improvement staff in place at the corporate level and would not need to staff in-house. Likewise, health information management staff would be reduced, under the assumption that improved organizational processes would reduce the needed staffing levels. An incoming contractor would likely outsource the duties of the communication center to a private security firm, who would be able to provide 24/7 staffing at a lower cost. The Administrative & General and Business Office departments would report fewer hours, by prohibiting overtime and slight reductions to budgeted FTEs. The reduction in nursing administration staff reflects nurses moving out of exclusively administrative roles and providing direct care in tandem. RNs and PNAs see the most sizable reduction in reported FTEs. This assumes that an incoming contractor would schedule nurses more efficiently and

thereby reduce the amount of reported overtime hours. Slight reductions to the Psychology, Social Services, and Peer Support would also occur under the recommended staffing scenario.

Stakeholder feedback and peer hospital comparisons informed PCG in the development of the recommended staffing scenario. As seen in the modeling above, certain departments do not experience any personnel changes between the two scenarios. Primarily in the case of the unaffected direct care departments, a reduction in staff was suspected to be detrimental to service delivery and quality of care. For non-direct care areas such as facility maintenance and custodial departments, PCG found no clear evidence of current inefficiencies. Therefore, the reported FTE counts from the FY15 baseline were not adjusted under the recommended staffing scenario.

Cost Model

FY15 Baseline Staffing Scenario

Option 1: Full Privatization assumes that all staffing levels remain the same as API's reported FY15 staffing model. These five year calculated costs are included in the table below.

Table 8.2.2: Option 1: Five Year Cost Projections (FY15 Baseline Staffing)

	FTEs	250.21	250.21
		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$133,524,647	\$133,524,647
	Travel, Services, Commodities, Capital	\$29,950,956	\$29,950,956
	Legal	\$603,225	\$603,225
	Cost of Services	\$164,078,828	\$164,078,828
	Profit Margin	\$6,539,024	\$13,078,048
	Total Contract Cost	\$170,617,852	\$177,156,876
Additional Costs to State	Contract Administration	\$25,592,678	\$26,573,531
	PERS	\$2,000,000	\$2,000,000
	IT Upgrades	-	-
	Total Overall Cost	\$198,210,530	\$205,730,408
	Total Cost to State	\$113,929,271	\$121,449,149

When examining the five year cost projections for this privatization option, and all subsequent options, it is important to note the bottom two rows: "Total Overall Cost" and "Total Cost to State". As mentioned in Section 7.3: Revenue Assumptions, *PCG calculated the total estimated five year funding by looking at current expenditures and trending them forward*. This total is influenced by patient revenue as well as other State funding sources, most notably funds from DSH payments and General Fund transfers. As our estimated five year funding assumes that all revenue and funding sources remain consistent in their proportion to total funding, PCG calculated the estimated State's share of total funding. This calculation assumes the State bears the cost of 50% of Medicaid revenue and DSH payments, based on Alaska's FMAP. The State's share of other inter-agency transfers was estimated at 69% as these funds are from a mixture of Medicaid and Non-Medicaid sources. The State provides 100% of the expected funding through the General Fund. Therefore, each privatization is weighed against two funding baselines: *estimated five-year total funding*, and *estimated five year State funding*. Section 7.3 also assumes that all additional costs or savings would be provided from or credited to the General Fund. Therefore, PCG calculated the total cost of each privatization option relative to the total estimated funding available, as well as the State's share of the total costs.

Under this full privatization option, the overall cost of operating API under a private contractor would range from \$198.2 million to \$205.7 million, depending on the contractor's ownership type. While there would be an initial

reduction in staffing related costs, the savings achieved are quickly counteracted by contract-related costs such as profit or margin and overhead.

The following table shows the total five-year cost compared to the State's financial baseline as reflected in General Fund dollars. Estimated annual expenditures for total operating budget and the State's share compared to the estimated future funding are also included in the following tables.

Table 8.2.3: Option 1: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$181,568,839	\$198,210,530	-	\$16,641,691
Annual Cost	\$36,313,768	\$39,642,106	9.2%	\$3,328,338
Five Year Cost to State	\$97,287,580	\$113,929,271	-	\$16,641,691
Annual Cost to State	\$19,457,516	\$22,785,854	17.1%	\$3,328,338

Table 8.2.4: Option 1: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$181,568,839	\$205,730,408	-	\$24,161,569
Annual Cost	\$36,313,768	\$41,146,081	13.3%	\$4,832,313
Five Year Cost to State	\$97,287,580	\$121,449,149	-	\$24,161,569
Annual Cost to State	\$19,457,516	\$24,289,830	24.8%	\$4,832,314

Under Option 1: Full Privatization, at the FY15 baseline staffing levels the State could not achieve overall cost-savings. In fact, this option would cost the State anywhere from \$16-\$24 million more over the five-year period. While the level of increase varies between a not-for-profit and a for-profit contractor, both would increase average annual spending by the State.

Recommended Staffing Scenario

Under the recommended staffing scenario, the overall five-year total cost decreases substantially, which is to be expected, with the reduction of FTEs. This reduction also reduces the total cost of contracted services, which lowers costs related to margin, termination liability, and contract monitoring expenditures. Table 8.2.5 provides a detailed view of the five year cost of full privatization under recommended staffing.

Table 8.2.5: Option 1: Five Year Cost Projections (Recommended Staffing)

	FTEs	225.99	225.99
		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$121,289,712	\$121,289,712
	Travel, Services, Commodities, Capital	\$29,950,956	\$29,950,956
	Legal	\$558,078	\$558,078
	Cost of Services	\$151,798,745	\$151,798,745
	Profit Margin	\$6,049,627	\$12,099,253
	Total Contract Cost	\$157,848,372	\$163,897,999
Additional Costs to State	Contract Administration	\$23,677,256	\$24,584,700
	PERS	\$2,000,000	\$2,000,000
	IT Upgrades	-	-
	Total Overall Cost	\$183,525,628	\$190,482,698
	Total Cost to State	\$99,244,369	\$106,201,440

Similar to the FY15 baseline staffing scenario, in the recommended staffing scenario, all savings found through the reductions in staff compensation and IT related expenses are quickly absorbed by contracting fees. However, this scenario is far closer to meeting the State's expected funding levels as seen in the table below.

Table 8.2.6: Option 1: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$181,568,839	\$183,525,628	-	\$1,956,789
Annual Cost	\$36,313,768	\$36,705,126	1.1%	\$391,358
Five Year Cost to State	\$97,287,580	\$99,244,369	-	\$1,956,789
Annual Cost to State	\$19,457,516	\$19,848,874	2.0%	\$391,358

Table 8.2.7: Option 1: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$181,568,839	\$190,482,698	-	\$8,913,859
Annual Cost	\$36,313,768	\$38,096,540	4.9%	\$1,782,772
Five Year Cost to State	\$97,287,580	\$106,201,440	-	\$8,913,860
Annual Cost to State	\$19,457,516	\$21,240,288	9.2%	\$1,782,772

Under Option 1: Full Privatization, the cost of operating over five years with the recommended staff reductions still continues to exceed current funding levels. Over a five-year period, it would cost the State approximately \$2-\$8 million more to contract these services.

Benefits and Drawbacks

There are a few benefits to Option 1. A private contractor would have the flexibility to set and adjust staff compensation autonomously. Furthermore, a private entity could implement different scheduling practices on an as needed basis to increase the efficiency of service delivery. In combination, this would allow for a more responsive approach to staffing API, based on the facility's immediate needs.

DHSS, and DBH specifically, could remove themselves from providing acute inpatient care and instead provide more of an administrative and oversight role. This would ultimately mean less day-to-day involvement with the operational aspects of API. A private contractor would likewise have the autonomy to increase efficiencies on an as needed basis without being restricted by existing agreements. However, as the cost models show, there are significant drawbacks to this option.

As illustrated above, the projected cost of both staffing scenarios exceed expected funding. Therefore, in order to even be cost neutral, further staff reductions would be necessary. This would require API to implement direct care staffing levels that are below minimal safe operational standards which would put DBH and the facility in a vulnerable position.

From a cost perspective, this option is the most expensive to the State. Contract monitoring costs are the highest in this option, as the scope of service is the largest. Given that API would have to implement staffing changes outside of what PCG considers a safe range, these funds would be more practically spent on providing direct care rather than contract administration.

Lastly, given the scope of duties, and the necessary contractual requirements that would have to be in place to ensure access and quality, this option could be cost prohibitive to a qualified potential contractor.

Figure 8.2.1

Option 1: Full Privatization	
Benefits	Drawbacks
<ul style="list-style-type: none"> • More flexible compensation could improve recruitment and retention of qualified employees • DBH no longer provides acute inpatient care, but acts as a contract administrator • Less headaches for DBH staff • Autonomy of a private contractor to implement efficiencies at API • Only way to implement service delivery improvements 	<ul style="list-style-type: none"> • Cost-prohibitive, even under Recommended Staffing Scenario • Without strong safeguards, further reductions of staff to unsafe levels needed to be financially viable • \$2 million in termination liability costs • Necessary contractual requirements could deter potential contractors

8.3. Option 2: Joint Operating Agreement

Special Assumptions

Option 2: Joint Operating Agreement is similar to Option 1: Full Privatization in that all day to day operations would again be managed by a private contractor. However, this scenario differs, in that the State could potentially play a more active role in the planning of operations and reduce some of the significant risks arising from principal-agent problems. This scenario would present itself as an agreement between DHSS, and a potential contractor. Unlike the previous privatization option, DHSS and the Trust would be more involved in the planning and execution of operations at API as well as play a contract monitoring and administration role. This would afford

the State enhanced organizational flexibility while being able to utilize less expensive private labor. All the assumptions for Option 1: Full Privatization apply to this option.

Cost Model

Option 2: Joint Operating Agreement should be considered more of distinct regulatory framework than a discrete cost model. Since all the assumptions are the same as Option 1: Full Privatization, so are the costs. The cost models are the same for Options 1 and 2.

Benefits and Drawbacks

A joint operating agreement between DBH and a private contractor would have benefits related to decreased staffing costs, increased efficiencies and more transparency to the State. A private contractor would still have the autonomy to implement changes to improve services delivery at API. However, the State would have greater “real-time” access to hospital operations to ensure potential negative outcomes are adequately assessed prior to implementation. In this option, the State could act as a liaison between a private entity and community providers and advocacy groups. This could alleviate some of the existing concerns regarding privatization. In short, the State could assume certain flexibilities and efficiencies available to a private-sector provider, while still being an active participant.

However, like Option 1, this option is not feasible at the current or recommended staffing levels. This would be coupled with high administrative costs on the State’s side as well as increased liability. Therefore, the costs outweigh the benefits in this option.

Figure 8.3.1

Option 2: Joint Operating Agreement	
Benefits	Drawbacks
<ul style="list-style-type: none"> • More flexible compensation could improve recruitment and retention of qualified employees • Autonomy of a private contractor to implement efficiencies at API • DBH plays more active role in the planning and execution of day-to-day operations at API • Establishes flexible legal vehicle for partnering with non-profits 	<ul style="list-style-type: none"> • Cost-prohibitive, even under Recommended Staffing Scenario • Reduction of staff to unsafe levels needed to be financially viable • \$2 million in termination liability costs • Necessary contractual requirements could deter potential contractors • Potential diffusion of management authority

8.4. Option 3: State Management with New Efficiencies

Special Assumptions

In developing our models for Option 3: State Management with New Efficiencies, PCG created what an idealized API would look like. At first glance, there are several potential benefits of keeping the hospital under the State’s management. In all other scenarios in which the facility is privatized, or a component of the facility is privatized, there are numerous costs associated with the contracting of services. This includes non-direct care expenditures related to profit, legal fees, benefit payouts, and contract administration. Therefore, it is important to examine the feasibility of keeping API under State management while implementing changes to control costs, particularly surrounding overtime. The assumptions of this Option were largely informed by feedback from stakeholders, peer hospital comparisons as well as clinical reviews of nursing practices (as discussed in Section 7.2). PCG identified current inefficiencies at API that have historically driven cost. A summary of the special assumptions influencing Option 3 are as follows.

- The State would see a 4% reduction in benefit costs for year one.
- The EMR center would be staffed by two IT staff members and one Nurse III (at full staffing), compared to the current IT staff member, Nurse III and Nurse IV.
- The State would continue to be responsible for all incurred capital costs and would manage the operation and maintenance of the physical plant.
- The State would continue to define FTEs as an employee working 1950 hours annually
- FTEs in select departments were reduced to simulate a reduction in overtime under the recommended staffing scenario
- The cost of worker's compensation is included in estimates for both public and private insurance. Estimates related to claim payout are not included in the model.
- The State would provide funding for the \$2.1 million needed for Meditech upgrades⁶⁷.
- Under the Recommended Staffing Scenario, additional termination liability costs of \$140,000 are added to account for a reduction of 17.50 FTEs. The rationale and evidential support for these assumptions are discussed in detail in Section 7.0

Staffing Scenarios

The following FTE counts were used to estimate costs for Option 3: State Management with New Efficiencies under the three staffing scenarios. The Recommended Staffing Scenario closely resembles the FTE counts used for Option 1: Full Privatization. However, unlike previous option certain positions are not able to be excluded as certain efficiencies are exclusive to a private provider. Bold values in the recommended staffing column indicate a change in FTE count.

⁶⁷ API Stakeholder Interviews, 8/22/2015

Table 8.4.1: FTEs per Department under Option 3: State Management with New Efficiencies

	Department	FY15 Baseline Staffing	Recommended Staffing
Administrative/Indirect	EMR	2.85	2.85
	Admin. & General	9.74	8.63
	Business Office	6.26	5.73
	Facility Operation	8.41	8.41
	Laundry & Linen	0.71	0.71
	Environmental Services.	11.03	11.03
	Nursing Admin.	10.17	8.47
	Central Svcs. & Supply	2.80	2.80
	Health Info Management	7.96	4.25
	Comm. Center	6.84	5.86
	Medical Director	0.00	0.45
	Quality Improvement	2.46	2.46
	Nursing Clerk	5.30	5.30
Nursing	Nursing PNA	82.19	76.91
	Nursing RN	44.95	42.07
Direct Care/ Other Medical	Pharmacy	2.82	2.82
	ASO	6.80	6.80
	Medical Services	2.68	2.68
Rehabilitation	Recreational Therapy	1.95	1.95
	Occupational Therapy	2.61	2.61
	Industrial Therapy	0.94	0.94
Psychology/Psychiatry	Psychology	6.41	5.40
	Psychiatry	9.80	9.80
	DJJ Psych Services	0.14	0.14
	Tele-psych	2.52	2.52
Social Work/Counseling	Social Services	10.01	9.37
	Peer Support	1.83	1.71
	TOTAL	250.21	232.71

The majority of staffing assumptions for departments experiencing reductions in staff are identical to the previous options. The communication center would see a reduction in FTEs, modeling reduced overtime. However, communication center staffing would remain higher under state management. This is due to the necessary personnel required to provide coverage. The Administrative & General and Business Office departments would report fewer hours, by prohibiting overtime which would result in slight reductions to budgeted FTEs. The reduction in nursing administration staff would be caused by nurses moving out of exclusively administrative roles to providing direct care in their respective units along with their current administrative duties. RNs and PNAs see the most sizable reduction in reported FTEs. These changes assume an incoming contractor would schedule nurses more efficiently and thereby reduce the amount of reported overtime hours. Slight reductions to the Psychology, Social Services, and Peer Support would also occur under the recommended staffing scenario.

As seen above, certain departments did not experience any personnel changes between the two scenarios. Primarily in the case of the unaffected direct care departments, a reduction in staff was suspected to be

detrimental to service delivery and quality of care. For non-direct care areas, PCG was not made aware of any perceived inefficiencies and so made no reductions in FTEs in those areas.

Cost Model

FY15 Baseline Staffing Scenario

PCG factored the aforementioned assumptions into our cost analysis of API staying under State management but taking actions to improve efficiencies. Unlike the previously discussed privatization options, Option 3: State Management with New Efficiencies, is only modeled for the recommended staffing scenario. This is because the FY15 reported staffing and associated costs were used as a benchmark for cost comparison between all other privatization options. As noted earlier in this report, an assumption of PCG's cost model is that through a mixture of patient revenue and State funding, estimated funding would be of a sufficient level to cover the projected costs of the hospital over a five year period. Therefore, the estimated five-year funding amount is the same as the estimated five year cost of providing services when using the FY15 baseline staffing and trending it forward.

Recommended Staffing Scenario

The Recommended Staffing Scenario models API after the new efficiencies have been implemented. These efficiencies include restructuring the staff composition of the EMR department to rely more heavily on less expensive IT staff, while reducing the hours being provided by nursing staff in the cost center. Hours, and subsequently FTE counts, in select administrative departments have been reduced to model a reduction in overtime. Furthermore, nursing administration, RNs and PNAs also see a reduction in reported hours to model reduced overtime while maintaining the necessary coverage. Therefore, the Recommended Staffing Scenario resembles the State managing and operating API similarly to a private contractor.

The following table shows the cost of running API after imposing a reduction from 250.21 FTEs to 232.71 FTEs. Table 8.4.3 provides an overview of the associated costs that went into this model.

Table 8.4.2: Option 3: Five Year Cost Projections (Recommended Staffing)

	FTEs	232.72
		Cost
Cost of Services	Salary & Benefits	\$136,313,356
	Travel, Services, Commodities, Capital	\$29,950,956
	Cost of Services	\$166,264,311
	PERS	\$140,000
Additional Costs	IT Upgrades	\$2,100,000
	Total Overall Cost	\$168,504,311
	Total Cost to State	\$84,223,052

Under this staffing scenario, further savings are found through the reduction of staff. The following table shows the relative impact of this scenario.

Table 8.4.3: Option 3: Estimated Expenditures Compared to Estimated Funding

	Estimated API Funding	Cost	Percent Variance	Dollar Variance
Five Year Total Cost	\$181,568,839	\$168,504,311	-	(\$13,064,528)
Annual Cost	\$36,313,768	\$33,700,862	-7.2%	(\$2,612,906)
Five Year Cost to State	\$97,287,580	\$84,223,052	-	(\$13,064,528)
Annual Cost to State	\$19,457,516	\$16,844,610	-13.4%	(\$2,612,906)

With a reduction of FTEs in this scenario, API could realize a five-year savings of \$13 million with the prescribed new efficiencies and still maintain safe staffing levels.

Benefits and Drawbacks

Under Option 3: State Management with New Efficiencies, the State would maintain its role in operating Alaska's only psychiatric hospital. A potential benefit of this is the State remains in control of this important asset and can ensure that the facility remains a safety net for Alaskans needing psychiatric services. This option allows for the State and DHSS to be proactive in implementing desired changes without paying an outside contractor to do so. Furthermore, it eliminates the risks and additional costs associated with contracting. As seen in Options 1 and 2, there are significant costs related to outsourcing services and contract monitoring. Under State management, the funds that would be spent on contracting can instead be used to improve patient treatment. Through implementing processes and scheduling in a way that aims to reduce overtime, the State could operate more effectively from both the cost and service delivery standpoint. Meanwhile, as changes to the State's benefits plan are implemented, the compensation gap between the private and public sector are also slated to narrow, reducing some of the cost saving potential of privatization.

Perhaps most importantly, the State would maintain control of managing the delivery of critical inpatient psychiatric services. While it can outsource this legislatively mandated responsibility, the continued management of the hospital by the State alleviates some of the risks with outside contracting. However, these cost savings are contingent on the API management providing the appropriate oversight to follow through with the proposed new efficiencies.

Figure 8.4.1

Option 3: State Management with New Efficiencies	
Benefits	Drawbacks
<ul style="list-style-type: none"> • Opportunity for DBH to implement efficiencies that will improve service delivery while containing costs • The State would retain full control of its only acute inpatient psychiatric hospital • No new additional costs related to procurement, contract administration, legal and margin • Cost-effective under the Current and Recommended Staffing Scenarios • Low termination liability costs (only applicable under Recommended Staffing Scenario) • Highest overall savings to the State under this option 	<ul style="list-style-type: none"> • Higher staffing expenditures related to public employees • More administrative burden associated with implementing changes • Contingent on DBH and API management successfully implementing changes • Potential pushback from labor unions when implementing changes

8.5. Option 4: Component Outsourcing

Option 4: Component Outsourcing is composed of five distinct sub-analyses. This option consists of the State retaining full operational and management control of API, while privatizing certain sub-components of staff. Under these scenarios, the State would retain its obligation to bear all costs related to capital, travel, medical supplies, and other services. A contractor, for the most part, would provide only staffing to the hospital, with administration limited to overseeing direct care functions. The proposed sub-options of Option 4 are:

- Option 4a. Communication Center Outsourcing
- Option 4b. Facility and Material Management Outsourcing
- Option 4c. Psychiatry and Medical Services Outsourcing
- Option 4d. Nursing Staff Outsourcing
- Option 4e. All Direct Care and Communication Center Outsourcing

Below you will find an overview of the cost benefits of privatizing certain functions. For each sub-analysis, current expenditures for the affected cost centers were compared currently managed to the modeled expenditures under privatization. This allows for easy comparison between the costs of public staffing versus private staffing.

For the sake of readability, detailed cost breakdowns are not included in the section, but instead the cost of each option is provided compared to current expenditures. This allows for more direct presentation of findings related to component outsourcing. The detail cost breakdowns are provided in Appendix A

OPTION 4A. COMMUNICATION CENTER OUTSOURCING

Special Assumptions

Option 4a: Communication Center Privatization examines the cost-saving potential of privatizing the communication center. PCG was informed that API's management had conducted a previous analysis to identify the cost saving potential of privatizing the communication center.

As of July 2016, the Communication Center cost API \$563,307 and utilized 6 staff members. PCG performed an analysis to determine the cost saving potential of privatizing this function. Since the communication center must be staffed at all times, a minimum of 4.20 FTEs is required to provide 24/7 coverage. However, unlike the reported FY15 staffing structure that contains extra FTEs to cover breaks, a private contractor would be able to utilize a wider labor pool. An additional 0.25 FTE was factored in to account for a manager to coordinate with API management. Using BLS data for security personnel, previous security related RFPs, and publicly available rate information from Doyon, a private security firm in Alaska, PCG determined communication center staffing could be obtained for individual rates of \$25 per hour. Furthermore, given the relative small size of affected staff, PCG excluded contract administration costs from this cost model, as it is assumed API currently has the adequate administrative infrastructure internally to manage this contract without any major new dedications of resources.

Cost Model

FY15 Baseline Staffing Scenario

Rather than calculating various cost scenarios based on staffing levels, PCG used a fixed amount for FTEs and costs when assessing the financial implications of privatizing the communication center. The following table shows the five year cost of a private communication center relative to current expenditures.

Table 8.5.1: Option 4a: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$3,538,700	\$3,080,041	-	(\$458,659)
Annual Cost	\$707,740	\$616,008	-13.0%	(\$91,732)
Five Year Cost to State	\$1,875,511	\$1,632,422	-	(\$243,089)
Annual Cost to State	\$375,102	\$326,484	-13.0%	(\$48,618)

Table 8.5.2: Option 4a: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$3,538,700	\$3,196,389	-	(\$342,311)
Annual Cost	\$707,740	\$639,278	-9.7%	(\$68,462)
Five Year Cost to State	\$1,875,511	\$1,694,086	-	(\$181,425)
Annual Cost to State	\$375,102	\$338,817	-9.7%	(\$36,285)

Over a five-year period, privatizing the communication center alone would reduce costs by anywhere between \$342,311 and \$458,659. However, a private contractor would not require the same number of FTEs to operate the communication center, as it would likely have a large labor pool to draw from to cover breaks, days off which currently must be absorbed through increased staff. Therefore, PCG modeled the communication center using the minimum 4.45 FTEs to provide 24-7 coverage. The following table shows the cost of a privatized communication center relative to current expenditures.

Recommended Staffing Scenario

Table 8.5.3: Option 4a: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$3,538,700	\$1,284,975	-	(\$2,253,725)
Annual Cost	\$707,740	\$256,995	-63.7%	(\$450,745)
Five Year Cost to State	\$1,875,511	\$681,037	-	(\$1,194,474)
Annual Cost to State	\$375,102	\$136,207	-63.7%	(\$238,895)

Table 8.5.4: Option 4a: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$3,538,700	\$1,332,281	-	(\$2,206,419)
Annual Cost	\$707,740	\$266,456	-62.4%	(\$441,284)
Five Year Cost to State	\$1,875,511	\$706,109	-	(\$1,169,402)
Annual Cost to State	\$375,102	\$141,222	-62.4%	(\$233,880)

While the net effect of a communication center privatization would not have a large effect on the overall operating budget of API, it produces substantial savings that can be implemented easily. Doing so would produce savings upwards of \$2 million dollars over five years. As the State makes considerations on whether or not to privatize certain components of API, the communication center remains a prime candidate, even if the remainder of operations stay under State management. Doing so would produce immediate savings to API's bottom line, and would not have an impact on quality of care as it is primarily an administrative function.

Figure 8.5.1

Option 4a: Communication Center Outsourcing	
Benefits	Drawbacks
<ul style="list-style-type: none"> Lower staffing expenditures due to the shift to a private workforce A private contractor would require fewer FTEs to provide around-the-clock coverage No negative impact to service delivery or quality of care No additional contract administration costs, could be provided in-house Availability of qualified contractors in Alaska 	<ul style="list-style-type: none"> Some additional costs related to contracting

OPTION 4B: FACILITY AND MATERIAL MANAGEMENT OUTSOURCING

Special Assumptions

The second variation of Option 4: Component Outsourcing analyzes the cost of a private contractor providing various maintenance and custodial services for the hospital. For this model, PCG included the following departments: facility operations, environmental services, and central services and supplies. The rationale for selecting these areas was based on API's organizational chart, which shows all three departments reporting to the same supervisor. Under this option, API would contract with a vendor that specializes in facility maintenance, custodial services and equipment sterilization. While the State would retain its obligation to provide funding for the ongoing maintenance and repair of capital assets, the incoming contractor would provide all personnel required to perform day to day maintenance and custodial duties. For this option, PCG only modeled the cost of a private contractor assuming responsibility of these operations, using the FY15 baseline staffing. PCG found no justification to assume that a private entity would reduce staff in these departments. Furthermore, given the relatively small size of the affected group, PCG excluded contract administration costs from this cost model, as it

is assumed API currently has the adequate administrative infrastructure internally to manage this contract without any new major dedications of resources.

Table 8.5.5: FTEs per Department under Option 4b: Facility and Material Maintenance Outsourcing

	FY15 Baseline Staffing
Facility Operations	8.41
Environmental Services	11.03
Central Services/Supply	2.80
Privatized Staff	22.25

Cost Model

FY15 Baseline Staffing Scenario

Using cost report data, PCG estimated the total expected personnel expenditures for facility maintenance and material management to be \$10.5 million over five years at the reported FY15 staffing level. The table below illustrates the cost of privatizing under this option.

Table 8.5.6: Option 4b: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$10,460,429	\$9,233,045	-	(\$1,227,384)
Annual Cost	\$2,092,086	\$1,846,609	-11.7%	(\$245,477)
Five Year Cost to State	\$5,544,028	\$4,316,643	-	(\$1,227,385)
Annual Cost to State	\$1,108,805	\$863,329	-22.1%	(\$245,476)

Table 8.5.7: Option 4b: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$10,460,429	\$9,581,084	-	(\$879,345)
Annual Cost	\$2,092,086	\$1,916,217	-8.4%	(\$175,869)
Five Year Cost to State	\$5,544,028	\$4,664,682	-	(\$879,346)
Annual Cost to State	\$1,108,805	\$932,936	-15.9%	(\$175,869)

At the FY15 baseline staffing level, the State could yield a modest savings of approximately \$879,345 to \$1,227,384 over five years by outsourcing facility and material management functions. Since, PCG found no reason to reduce the overall FTEs in the affected departments, Option 4b: Facility and Material Maintenance has a single cost profile.

Figure 8.5.2

Option 4b: Facility and Material Management Outsourcing	
Benefits	Drawbacks
<ul style="list-style-type: none"> Lower staffing expenditures due to the shift to a private workforce No negative impact to service delivery or quality of care No additional contract administration costs, could be provided in-house Availability of qualified contractors in Alaska 	<ul style="list-style-type: none"> Some additional costs related to contracting

OPTION 4C: PSYCHIATRY AND MEDICAL SERVICES OUTSOURCING

Special Assumptions

The next variation of Option 4: Component Outsourcing, is privatizing psychiatry including tele-psych, and medical staff including physicians and physician assistants. Like other previous scenarios, this assumes that a healthcare staffing firm would provide staffing for these areas, while the State maintains all other departments as well as non-personnel related costs for the hospital. Generally, these are the most expensive positions at API, so the State could potentially find savings through a private entity. Based on feedback and existing literature, PCG determined it would not be appropriate to reduce staff in the affected departments. Given, the high census pressure at the facility, physicians, PAs, psychiatrists and all other staff included in these departments play a critical role in treating patients in a particularly high pressure environment. Therefore, for Option 4c: Psychiatry and Medical Services Outsourcing, PCG modeled a single cost model using the following FTE counts.

Table 8.5.8: FTEs per Department under Option 4c: Psychiatry and Medical Services Outsourcing

	FY15 Baseline Staffing
Medical Services	2.68
Psychiatry	9.80
Tele-Psych	2.52
Privatized Staff	15.00

Cost Model

FY15 Baseline Staffing Scenario

Similar to previous examples, FY15 staffing expenditures were trended forward for the affected staff. Under State employment, the affected cost centers are projected to cost a total of \$22.1 million over the next five years. With this baseline, PCG compared the estimated cost of a not-for-profit and for-profit provider using these counts. Table 8.5.9 summarizes the findings.

Table 8.5.9: Option 4c: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$22,127,758	\$26,293,222	-	\$4,165,464
Annual Cost	\$4,425,552	\$5,258,644	18.8%	\$833,092
Five Year Cost to State	\$11,727,711	\$15,893,176	-	\$4,165,465
Annual Cost to State	\$2,345,542	\$3,178,635	35.5%	\$833,093

Table 8.5.10: Option 4c: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$22,127,758	\$27,299,214	-	\$5,171,456
Annual Cost	\$4,425,552	\$5,459,843	23.4%	\$1,034,291
Five Year Cost to State	\$11,727,711	\$16,899,168	-	\$5,171,457
Annual Cost to State	\$2,345,542	\$3,379,834	44.1%	\$1,034,292

Under the FY15 baseline staffing, the cost of contracting these services would be cost-prohibitive. When estimating the private compensation, these positions generally saw a smaller difference compared to other cost centers. As noted in the stakeholder interviews, psychiatrists and mid-level provider compensation is substantially higher in the private sector in Alaska. Therefore some of the assumed savings brought by privatization through a reduction in benefits are not applicable to this option. With the added fees associated with outsourcing services, the overall expense of Option 4c: Psychiatry and Medical Services Outsourcing further increase, making this option infeasible.

Figure 8.5.3

Option 4a: Psychiatry and Medical Services Outsourcing	
Benefits	Drawbacks
<ul style="list-style-type: none"> No reduction in hospital staff for psychiatrists, physicians and mid-level providers Compensation could potentially increase under a private contractor, improving recruitment and retention Autonomy of a private contractor to implement efficiencies at API 	<ul style="list-style-type: none"> High contract related costs counteract savings Cost-prohibitive under Current and Recommended Staffing Scenarios Reduction of staff to unsafe levels needed to be financially viable Lack of clear providers, aside from locum tenens agencies

OPTION 4D: NURSING STAFF OUTSOURCING

Special Assumptions

Option 4b: Nursing Staff Outsourcing models the effects of solely privatizing the nursing staff. In this analysis, PCG modeled the fiscal impacts of a private entity providing all of API's RNs, PNAs, nurse administrators and clerks. Like the previous example, FY15 staffing expenditures were trended forward for the affected staff. Under State employment, the affected cost centers are projected to cost a total of \$76.1 million over five years. With this baseline, PCG compared the estimated cost of a not-for-profit and for-profit provider for each of the staffing scenarios and estimated the average annual increase or decrease for both scenarios.

Staffing Scenarios

Table 8.5.11: FTEs per Department under Option 4d: Nursing Staff Outsourcing

	FY15 Baseline Staffing	Recommended Staffing
Nursing Administration	10.17	8.47
Nursing Clerks	5.30	5.30
PNAs	82.19	76.91
RNs	44.95	42.07
Privatized Staff	142.60	132.75

Between the FY15 Baseline Staffing Scenario and the Recommended Staffing Scenario, the majority of the reductions come from nursing administration and the PNAs. This assumes that some RNs currently in administrative roles transition to spending more time with patients in their respective unit at API. Doing so would maintain adequate nursing coverage while simultaneously reducing cost.

Cost Model

FY15 Baseline Staffing Scenario

When compared to current expenditures at API, the table below shows the effects of implementing Option 4b at the reported FY15 staffing levels relative to total five-year funding.

Table 8.5.12: Option 4d: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$76,180,507	\$80,413,385	-	\$4,232,878
Annual Cost	\$15,236,101	\$16,082,677	5.6%	\$846,576
Five Year Cost to State	\$40,375,669	\$44,608,547	-	\$4,232,878
Annual Cost to State	\$8,075,134	\$8,921,709	10.5%	\$846,575

Table 8.5.13: Option 4d: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$76,180,507	\$83,460,330	-	\$7,279,823
Annual Cost	\$15,236,101	\$16,692,066	9.6%	\$1,455,965
Five Year Cost to State	\$40,375,669	\$47,655,492	-	\$7,279,823
Annual Cost to State	\$8,075,134	\$9,531,098	18.0%	\$1,455,964

As seen above, the transition to a private nursing staff would cost the State more than the expected funding for the four affected cost centers. The increase in costs range from roughly \$4 million to \$7 million over a five year period. Therefore, in order for the nursing department to be cost-effective under a private entity, further reduction in staff would be necessary.

Recommended Staffing Scenario

Table 8.5.14: Option 4d: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$76,180,507	\$74,543,836	-	(\$1,636,671)
Annual Cost	\$15,236,101	\$14,908,767	-2.1%	(\$327,334)
Five Year Cost to State	\$40,375,669	\$38,738,998	-	(\$1,636,671)
Annual Cost to State	\$8,075,134	\$7,747,800	-4.1%	(\$327,334)

Table 8.5.15: Option 4d: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$76,180,507	\$77,365,180	-	\$1,184,673
Annual Cost	\$15,236,101	\$15,473,036	1.6%	\$236,935
Five Year Cost to State	\$40,375,669	\$41,560,342	-	\$1,184,673
Annual Cost to State	\$8,075,134	\$8,312,068	2.9%	\$236,934

Under a not-for-profit vendor, API could procure nursing services at \$1,636,670 lower than current estimated expenditures over five years. This scenario represents the needed FTEs to provide adequate nursing coverage in the units at API, and is therefore feasible. However, savings would not be achieved under a for-profit provider due to higher margin. While other states have had success in privatizing their nursing departments, a potential issue for API could be procuring a not-for-profit vendor who is able to meet the needs of the facility. Furthermore, a private contractor's nursing staff managed by a management team of State staff may pose additional issues.

Figure 8.5.4

Option 4d: Nursing Staff Outsourcing	
Benefits	Drawbacks
<ul style="list-style-type: none"> • Lower staffing expenditures due to the shift to a private workforce • No negative impact to service delivery or quality of care • Modest cost savings can be found through safe staff reductions • Autonomy of a private contractor to implement efficiencies at API 	<ul style="list-style-type: none"> • With current FTEs, high contract related costs counteract savings • Cost-prohibitive under FY15 Baseline Staffing Scenario • \$1,400,000 in termination liability costs • Possible difficulties finding a qualified contractor

OPTION 4E: COMPREHENSIVE OUTSOURCING

Special Assumptions

Option 4e models API as if the State retained only hospital administration duties, with all direct care, maintenance and custodial functions being contracted out to a private provider. In this model, it is assumed that the State would continue to cover all non-staff related costs such as services, commodities, travel, and capital costs. Outside of these specific assumptions, the following factors apply to our cost models.

- Under this scenario, the State would be responsible for all incurred capital costs outside of personnel related expenditures for maintenance staff.
- A range of margins are modeled and applied to the total cost of services: a 4% minimum margin, typical of a not-for-profit company, as well as an 8% margin more reflective of the expectations of a for-profit company.
- Private salaries are modeled at 13.7% higher than current state salaries. Benefits compose 22% of private total compensation
- A private operator classifies an FTE as an employee working 2080 a week. This would reduce overtime.
- The cost of worker's compensation is included in estimates for both public and private insurance.
- Legal costs are benchmarked at 0.369% of the total cost for contracted services
- The State will provide funding for the \$2.1 million needed for Meditech upgrade. (Included in funding projections)
- Contract monitoring costs are estimated at 15% of total contract value
- The State's termination liability is estimated at \$1,737,000 with 217.26 FTEs being privatized under this option. The rationale and evidential support for these assumptions are discussed in detail in Section 7.0.

Staffing Scenarios

PCG modeled Option 4e. Comprehensive Outsourcing for both the current and recommended staffing scenarios. In this option, departments at API that stay under State management would not see a reduction in FTEs. Rather the decreased counts seen between the three staffing scenarios are only reflective of the privatized departments performing direct care and the communication center. Based on the preciously discussed assumptions, certain departments remain at the same FTE level, where others see slight reductions based on potential efficiencies. The table below, shows the impact of each staffing scenario on the affected cost centers at API:

Table 8.5.16: FTEs per Department under Option 4e: Comprehensive Outsourcing

	Department	FY15 Baseline Staffing	Recommended Staffing
Administrative/Indirect	Facility Operation	8.41	8.41
	Environmental Services.	11.03	11.03
	Nursing Admin.	10.17	8.47
	Central Svcs & Supply	2.80	2.80
	Comm. Center	6.84	4.45
	Medical Director	0.00	0.45
	Nursing Clerk	5.30	5.30
Nursing	Nursing PNA	82.19	76.91
	Nursing RN	44.95	42.07
Direct Care/ Other Medical	ASO	6.80	6.80
	Medical Services	2.68	2.68
Rehabilitation	Recreational Therapy	1.95	1.95
	Occupational Therapy	2.61	2.61
	Industrial Therapy	0.94	0.94
Psychology/Psychiatry	Psychology	6.41	5.40
	Psychiatry	9.80	9.80
	Telepsych	2.52	2.52
Social Work/Counseling	Social Services	10.01	9.37
	Peer Support	1.83	1.71
	TOTAL	217.26	203.70

Cost Model

An initial step in assessing the feasibility of this option was to examine the fiscal impact of transitioning to a private staff for only the affected cost centers. This provides a more pinpointed view of the potential cost savings achieved through this variation of privatization. FY15 staffing expenditures were trended forward for the affected staff. Under State employment, the affected cost centers are projected to cost a total of \$131,173,383 over five years. With this baseline, PCG compared the estimated cost of a not-for-profit and for-profit provider for both of the staffing scenarios and estimated the average annual increase or decrease for. The table below summarizes the findings.

*FY15 Baseline Staffing Scenario***Table 8.5.17: Option 4e: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)**

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$131,173,383	\$142,297,800	-	\$11,124,417
Annual Cost	\$26,234,677	\$28,459,560	8.5%	\$2,224,883
Five Year Cost to State	\$69,521,893	\$80,646,311	-	\$11,124,418
Annual Cost to State	\$13,904,379	\$16,129,262	16.0%	\$2,224,883

Table 8.5.18: Option 4e: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$131,173,383	\$147,700,384	-	\$16,527,001
Annual Cost	\$26,234,677	\$29,540,077	12.6%	\$3,305,400
Five Year Cost to State	\$69,521,893	\$86,048,894	-	\$16,527,001
Annual Cost to State	\$13,904,379	\$17,209,779	23.8%	\$3,305,400

As seen above, the switch to privatization does not yield any savings with when modeled with the reported FY15 staffing. While the overall compensation costs are generally lower for a private staff, the additional fees related to contracting counteract the expected savings. Furthermore the reduction in total compensation is not directly proportionate, as some departments report high overtime usage which inflates personnel costs. Therefore, this model suggests that simply shifting to a private staff is not inherently more cost-effective, and reductions in FTEs would be required to be viable.

Recommended Staffing Scenario.

Table 8.5.19: Option 4e: Estimated Expenditures Compared to Estimated Funding (Not-For-Profit)

	Estimated API Funding	4% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$131,173,383	\$134,036,457	-	\$2,863,074
Annual Cost	\$26,234,677	\$26,807,291	2.2%	\$572,614
Five Year Cost to State	\$69,521,893	\$72,384,967	-	\$2,863,074
Annual Cost to State	\$13,904,379	\$14,476,993	4.1%	\$572,614

Table 8.5.20: Option 4e: Estimated Expenditures Compared to Estimated Funding (For-Profit)

	Estimated API Funding	8% Margin	Percent Variance	Dollar Variance
Five Year Total Cost	\$131,173,383	\$139,121,508	-	\$7,948,125
Annual Cost	\$26,234,677	\$27,824,302	6.1%	\$1,589,625
Five Year Cost to State	\$69,521,893	\$77,470,019	-	\$7,948,126
Annual Cost to State	\$13,904,379	\$15,494,004	11.4%	\$1,589,625

Even through a reduction of FTEs from 217.26 to 203.70, the Recommended Staffing Scenario fails to fall below the estimated funding for the privatized departments. Therefore, a private company would be unable to deliver services at API without reducing staff below minimum levels for ensuring adequate service delivery. Therefore, Option 4e: Comprehensive Outsourcing is not a feasible option for privatization.

Figure 8.5.5

Option 4e: Comprehensive Outsourcing	
Benefits	Drawbacks
<ul style="list-style-type: none"> • Lower staffing expenditures due to the shift to a private workforce • Autonomy of a private contractor to implement efficiencies at API • DBH maintains administrative presence in API 	<ul style="list-style-type: none"> • High contract related costs counteract savings • Cost-prohibitive under Current and Recommended Staffing Scenarios • Reduction of staff to unsafe levels needed to be financially viable • \$1,737,000 in termination liability costs • Possible difficulties finding a qualified contractor

Overall Impact of Option 4a-4e

PCG modeled the cost of privatizing different components at API compared to the likely funding for each option's respective cost centers. This allowed for a comparison of current departmental costs to projected departmental costs. Option 4a: Communication Center Outsourcing, and Option 4b: Facility and Material Management Outsourcing showed that privatization was implementable at the current FTE counts of their respective departments, even when accounting for the additional costs related to contracting. Option 4d: Nursing Staff Outsourcing showed nominal savings under a not-for-profit contractor, under the recommended staffing scenario. For Options 4c and 4e, there were no savings when privatized, even when estimating safe reductions in staff. While certain options present themselves as avenues in which the State could lower General Fund spending, none of the variations of Option 4: Component Outsourcing would lower costs substantially enough to have a significant effect on the overall operating budget of the facility.

Option 4: Component Outsourcing Benefits and Drawbacks

PCG has modeled five distinct options related to privatizing certain components of its staff. A potential benefit of privatization of some of the components would be to take advantage of less expensive labor, as our estimates for private-sector employees see a sizable reduction in total compensation due to lower employee benefits. In certain positions, such as PNAs and the communication center staff, transitioning to private labor could also lead to more appropriate compensation relative to market rates. In a way the State would cease to "over-pay" for certain positions due to the inherent flexibility that a private contractor could provide. PCG noted that in Option 4a: Communication Center Outsourcing, Option 4b: Facility and Material Management and for one scenario of Option 4d: Nursing Staff Outsourcing, privatizing can cost the state less than its current expenditures, even when accounting for profit and contract administration.

An additional benefit would be that the State would retain control of the facility while still taking advantage of perks available in the private sector. This would allow API to more easily ensure compliance with quality standards and ease stakeholder concerns regarding privatization.

However, as seen in the options above, certain options would not create the necessary cost savings to reduce expenditures without large reductions in staff. If components of API were to be outsourced, the State would need to continue to explore means of increasing the organizational efficiencies within its own organization in tandem with private outsourcing.

9.0. FINDINGS AND RECOMMENDATIONS

9.1. The Role of API within an Evolving Behavioral Health System

To this point, the feasibility study's analysis of service delivery at API has been confined mainly to reporting on the key indicators used to measure appropriate access to inpatient psychiatric care as well as the quality of that care. The purpose of the analysis, as detailed in Section 6.5-6.11, was 1) to identify current deficiencies in API's service delivery, for which privatization might serve as a potential remedy; and 2) to establish a baseline standard of service delivery to which a private operator would need to be held accountable when assuming management of the facility. However, little has been said so far about the evolution of the broader Alaskan behavioral health system or the extent to which that evolution reflects major changes in the population's demand for care, community providers' capacity to offer needed services, or overall standards of service delivery. In order to determine the degree to which privatization is an appropriate response to system challenges, it is necessary to assess how these dominant trends impact API and its role within the service delivery system.

Obviously, this study does not pretend to offer an in-depth system study, but it can indicate a number of significant service trends that are likely to affect a private contractor's performance and what sort of expectations the State can reasonably place on any future administrator of the hospital. In PCG's view, increasing census pressure—due to a range of factors—could prove determinative for a private entity's ability to improve or maintain service delivery standards in the near future, despite the fact that it would have little direct control over many of the factors contributing to census pressure.

It is clear not only that the demand for inpatient beds is growing, but also that API's options for responding proactively to this demand are limited. As previously noted, API has already made significant changes to its service delivery model to accommodate heightened demand for beds, focusing exclusively on acute psychiatric care with short lengths of stay. While many state hospitals continue to aim at decreasing their average lengths of stay in order to improve the cost effectiveness of care and ensure that care is delivered in the most appropriate setting, API's average lengths of stay are among the lowest in the nation, and it is doubtful whether the hospital can or should decrease lengths of stay as a proactive response to state demand for beds. Certainly, the high rates of readmission witnessed at API are a contributing factor to its current census pressure, and some of this pressure could be decreased by improving the system's success at keeping behavioral health consumers in the community and preventing readmission after stabilization. While it is probably the case that with the Department's present focus on Medicaid and behavioral health reform efforts, including efforts to greatly improve access to a broader range of behavioral health services, API could improve the effectiveness of treatment to lower readmissions. However, it is also true that API's high readmission rates also reflect the present lack of resources within the community system. Many consumers lack a place to go after they are discharged from API and remain in a cycle of hospitalization.

It may be true that stagnant funding and insufficient investment in community services are a major reason for increased census pressure on API. This situation no doubt has also contributed to the fact that many behavioral health consumers have also ended up within the correctional system. In recent years, the State has identified the need to address the criminalization of mental illness by improving diversion efforts to promote appropriate treatment within the public mental health system rather than the correctional system. Of course, the endeavor to get people out of Alaska's jails and prisons and into community treatment, without ensuring a concomitant increase in community capacity, ultimately only generates census pressure on API. In the event of privatization, a contractor would inherit this situation, but it is unclear that a private entity would be in any better position to respond to deficiencies in the community system than a state-managed hospital.

While most stakeholders acknowledged that capacity issues in the community system are an aggravating factor in the census pressures facing API, a number of stakeholders asked whether there are in fact a sufficient number of inpatient beds within the state. This is also an important question to answer, because if the census pressure on API is a reflection of inadequate inpatient capacity, and not just inefficiencies in the system of care leading to

improper utilization, then it is hard to see how privatization will help to solve the difficulties stemming from lack of service capacity.

PCG did not find a clear lack of inpatient capacity within our review of the broader service system. Although no consensus exists regarding the optimum number of inpatient psychiatric beds needed for effective mental health care within a system, the available literature provides sufficient evidence to establish an approximate lower and upper threshold of required beds. Arguably, Alaska falls within those broad margins.

The studies published to date show that a variety of factors influence appropriate bed capacity. Among these are the range of services offered through the community-based system, the capacity of the community-based system, the prevalence of mental illness, and the length of stay, all of which impact the number of inpatient psychiatric beds required within a behavioral health system. The results of these studies are summarized below:

Table 9.1.1: Benchmarks for System Bed Demand

Year	Author(s)	Methodology	Conclusion
1969	British Department of Health and Social Security	Determined by the actual utilization of long-stay beds, projected utilization of long-stay beds based on demographic trends, current utilization of short-stay beds, and transition of patients with dementia to alternative facilities.	Acute beds needed: 50/100,000 persons
1986	Goplerud, E. N.	Derived projected inpatient psychiatric bed needs using seven methodologies and compared the predictions with actual utilization in 16 metropolitan areas.	Utilization rates are correlated with licensed bed capacity in areas with capacity at or below 50 beds/100,000 persons but plateaued in areas with greater than 50 beds/100,000 persons. Additionally, no methodology accurately predicted utilization.
1987	Hafner, H.	Collection of psychiatric bed capacity data within developed countries to determine the capacity of mental health systems to meet the needs of schizophrenic patients.	Acute adult short-stay bed capacity needed: 50-80/100,000 persons; Acute adult long-stay bed capacity: 30-60/100,000 persons
1988	Royal College of Psychiatrists Working Party	Analysis of actual utilization of acute psychiatric beds and identification of criteria affecting utilization.	Average adult bed capacity: 43/100,000 persons; Alternative criteria must be developed to determine bed need.
1998	Davis, G.E., Walter, L.E., Davis, G.L.	Identified quality of care, determined with the accuracy of predicting hospital and community length of stay and patient acuity, and then determined optimum bed capacity.	Bed capacity needed: 40/100,000 persons; Minimum adult bed capacity: 22/100,000; Optimum adult bed capacity: 31/100,000 persons
2010	Torrey et al.	Polled 15 experts on psychiatric care.	Bed capacity needed: 40-60/100,000 persons

Year	Author(s)	Methodology	Conclusion
2013	Jones, R.	Determined an optimal occupancy rate using quality indicators, average occupancy, and the rate at which patients are turned away due to full capacity.	Maximum safe occupancy rate: 85% (lower for facilities <100 beds)

Despite the limitations evident in these studies, a comprehensive review of literature on this subject yields insight into trends in psychiatric hospital utilization and capacity that can be used to set benchmarks for upper and lower limits on appropriate bed capacity within a state's behavioral health system. For example, despite the fact that the earliest benchmarking established 50 beds per 100,000 as the *minimum* capacity required within a behavioral health system, one of the first studies to rely on post-deinstitutionalization data found evidence that the 50 bed criterion indicates more of an upper limit to appropriate capacity. Specifically, the research published in 1986 by Eric N. Goplerud found that utilization correlates with licensed bed capacity in communities with 50 or fewer beds per 100,000 people. Under that threshold utilization increases as bed capacity increases. However, in communities with more than 50 beds per 100,000 people, utilization ultimately plateaus, indicating that 50 beds per 100,000 is the maximum amount needed to serve a population. As capacity above 50 beds per 100,000 did not result in an increase in volume of utilization, 50 beds per 100,000 is the upper limit of appropriate psychiatric bed capacity rather than the lower limit.

The 1998 study conducted by Davis et al. is one of the most recent studies, and offers the most sophisticated research design. The approach developed in that work consisted of the use of artificial neural networks to determine the "optimal" number of state hospital beds needed within a behavioral health system, based on an analysis of treatment outcome data both within the hospitals and in community settings in the State of Maine. This study indicated the need for hospital beds within a minimum and maximum of 22 to 40 beds per 100,000, identifying 31 beds per 100,000 as "optimal," to the extent that this capacity was characteristic of the lowest levels of overall acuity, or the ratio at which consumers in the hospitals and in the community were collectively the least ill. When these studies are taken together, it appears that a generally accepted criterion of appropriate bed capacity lies within a range of 31-50 inpatient psychiatric beds per 100,000 individuals.

Of course, API by itself does not provide all of the capacity needed by the State. According to 2013 population estimates,⁶⁸ API's inpatient beds make up a capacity of 10.9 beds per 100,000, which is relatively low in comparison to available state hospital beds in other states. However, when community inpatient beds are taken into account—including the Designated Evaluation and Treatment beds at Bartlett Regional Hospital and Fairbanks Memorial Hospital, as well as those at North Star—then system capacity is approximately 30.2 beds per 100,000, which is near the lower thresholds of adequate capacity. That said, reference to bed capacities in aggregate can be misleading, since a large proportion of these beds are open only to children and adolescents. Likewise, Alaska has one of the lowest proportion of forensic beds of any state; where forensic beds make up 40% of state hospital beds on average, only 16% of Alaska's beds (10 beds total) are designated as forensic beds. While it is impossible to conclude with certainty as to whether the State faces an absolute shortage of beds at present, it is likely that efforts to recruit additional private providers to maintain inpatient psychiatric beds will be successful in allowing the State to keep pace with capacity demands.

Of course, capacity is not the same as utilization. Deriving an estimate of needed bed capacity from expected utilization requires a further step and an additional factor: **Occupancy Rate**. Although the occupancy rate is in part a policy choice that must be decided based on state need, clinical guidelines suggest that an 85% occupancy rate is optimal. An 85% occupancy rate is significant from a clinical and an administrative perspective, because it represents a kind of critical threshold, beyond which facilities begin to suffer a variety of effects related to patient

⁶⁸ This year was used because it is the most recent year in which hospital bed capacity was available for all states.

overcrowding and staff “busyness.” While occupancy above 85% is perfectly acceptable for short periods of time, persistent overutilization of psychiatric hospitals can be dangerous for both patients and staff member and has been shown to increase the following statistics:

- Hospital acquired infection rates
- Staff dissatisfaction, burn-out, and use of anti-depressants
- Treatment errors
- Unnecessary deaths
- Serious incidents causing major or extreme harm
- Waitlists
- Aggressive patient behavior

A 2013 study found that 85% was the optimal occupancy rate for a network of inpatient psychiatric hospitals to avoid these adverse consequences while maximizing infrastructure and revenue.⁶⁹ Above that rate, hospitals experience the risks associated with overutilization and crowded facilities. Below that rate hospitals are likely to have underutilized bed capacity and higher spending per recipient. For this reason, an 85% statewide occupancy rate is clinically recommended.

It should also be noted that hospitals with fewer than 100 beds, as typified by API, may require a lower occupancy rate in order to avoid the effects of overutilization, whereas the significantly larger hospitals found in other states can operate at higher occupancy rates without experiencing these effects. While PCG noted that API’s average census appeared to fall within appropriate ranges, it was also clear that the occupancy rate has increased to the critical threshold. In FY13, the average occupancy rate was 71%; in FY14, it was 72%. However, in FY15, it was 81%, and currently, it is reported that API is regularly at maximum capacity.

PCG has raised these considerations in order to indicate that, in the event of privatization, managing the census will be key to a private provider’s ability to maintain current service delivery standards, as well as to note that, apart from improving readmission rates, API’s controls over the census are somewhat indirect. The increased efficiencies it can bring to bear are also limited and would need to be implemented in partnership with community providers.

We have also detailed these issues in order to caution against reading our staffing recommendations as a prescription for “correct” staffing levels, as if these can be determined irrespective of utilization. We have tried to make clear that our estimates of staffing need are based on a retrospective analysis of FY15 staff levels, which included not only a complete picture of compensation requirements, but also a complete understanding of hospital utilization over the course of the fiscal year. PCG’s determination of appropriate levels of FTEs are based on the staff-to-patient ratios evident during the annual period. To the extent that utilization has increased, and that occupancy nears critical thresholds, the FTEs needed to maintain appropriate staffing levels will obviously change. For this reason, neither the privatized staffing models, nor the state-managed alternative, should be regarded as a concrete blueprint of the number of positions that can be cut. The appropriate number of staff, especially direct care personnel, is entirely dependent on the level of utilization.









9.2. Privatization Recommendations

Based on the separate cost-benefit analyses presented in Section 8.0, PCG’s assessment is that a blended approach to privatization is in the best interest of API and the State. Our findings demonstrate that continued State management is not only the most advantageous route for generating overall cost savings, but that it also avoids many of the risks involved in contracting out the management of critical public infrastructure. However, this alternative is also compatible with a number of the outsourcing options under review, including privatization of the communication center and facility and materials management. It is probable that savings can be maximized by

⁶⁹ Rod Jones

privatizing some or all of these non-core services, with direct care services remaining under state management to prevent harm to service delivery or quality outcomes.

The table below summarizes PCG's findings and recommendations for each of the privatization options submitted for cost-benefit analysis:

Privatization Option	Feasibility	Findings and Recommendations
1: Full Privatization		Cost-benefit analysis revealed that, even after significant staff reduction, when all transition costs, contract monitoring costs, and provider margins are considered, this option proves to be more expensive to the state over a likely 5-year contract period. The additional staff reductions needed for budget neutrality would likely diminish service delivery.
2: Joint Operating Agreement		As a variation of full privatization, this option failed to generate cost savings for the same reasons.
3: State Management		Cost-benefit analysis showed that implementing greater efficiencies in administrative functions and nursing staffing patterns could deliver the greatest amount of cost savings of all the options.
4a: Communication Center		While this option involves relatively few hospital personnel, expected changes to compensation and the need for fewer staff under a private contractor would yield the highest percentage of savings for any of the options. These services could also be supplied by a viable marketplace of competing vendors.
4b: Facility and Material Management		This option involves roughly a tenth of hospital personnel and appears to deliver only modest cost savings. However, like security services, these maintenance and environmental services can be readily procured from a viable marketplace of vendors.
4c: Psychiatric and Medical Services		Unlike many categories of hospital staff, levels for psychiatric and medical staff are not typically reduced under privatization, nor is their compensation significantly decreased. In many cases, private entities will increase compensation to better support recruitment and retention of these scarce personnel. While these changes may improve service delivery, they do not yield cost savings. Aside from the potential for increased cost, PCG also cautions against privatizing these services due to concerns over a lack of clear providers, aside from locum tenens agencies.
4d: Nursing Services		From a fiscal perspective, nursing services are a potentially fruitful area for privatization, due to the fact that nursing staff make up 58% of all API personnel, with the greatest potential for savings through staff reductions and changes to benefits and compensation levels. While cost-benefit analysis showed that modest staff reductions—and associated cost savings—could be achieved without diminishing service delivery, it is not clear that a private provider could significantly lower overall compensation levels for nursing personnel without affecting recruitment and retention. Nor is it clear that a robust marketplace for these services exists in Alaska. Many of the identified improvements in nursing services could also be implemented under current state management.
4e: Comprehensive Outsourcing		Cost-benefit analysis revealed that this option failed to produce cost savings, making it infeasible on fiscal grounds. The higher cost was due largely to expense of privatizing psychiatric services.

APPENDIX: OPTION 4: COMPONENT OUTSOURCING DETAILED FIVE YEAR COST**Option 4a: Communication Center Outsourcing Detailed Five Year Cost****Table A.1: Option 4a: Five Year Cost Projections (FY15 Baseline Staffing)**

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$2,908,694	\$2,908,694
	Travel, Services, Commodities, Capital	-	-
	Legal	-	-
	Cost of Services	\$2,908,694	\$2,908,694
	Profit Margin	\$116,348	\$232,695
	Total Contract Cost	\$3,025,041	\$3,141,389
Additional Costs to State	PERS	\$55,000	\$55,000
	Contract Administration	-	-
	Total Overall Cost	\$3,080,041	\$3,196,389
	Total Cost to State	\$1,632,422	\$1,694,086

Table A.2: Option 4a: Five Year Cost Projections (Recommended Staffing)

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$1,182,668	\$1,182,668
	Travel, Services, Commodities, Capital	-	-
	Legal	-	-
	Cost of Services	\$1,182,668	\$1,182,668
	Profit Margin	\$47,307	\$94,613
	Total Contract Cost	\$1,229,975	\$1,277,281
	PERS	\$55,000	\$55,000
Additional Costs to State	Contract Administration	-	-
	Total Overall Cost	\$1,284,975	\$1,332,281
	Total Cost to State	\$681,037	\$706,109

Option 4b: Facility and Material Management Outsourcing Detailed Five Year Cost**Table A.3: Option 4b: Five Year Cost Projections (FY15 Baseline Staffing)**

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$8,674,996	\$8,674,996
	Travel, Services, Commodities, Capital	-	-
	Legal	\$32,011	\$32,011
	Cost of Services	\$8,707,006	\$8,707,006
	Profit Margin	\$348,039	\$696,078
	Total Contract Cost	\$9,055,045	\$9,403,084
Additional Costs to State	PERS	\$178,000	\$178,000
	Contract Administration	-	-
	Total Overall Cost	\$9,233,045	\$9,581,084
	Total Cost to State	\$4,316,643	\$4,664,682

Option 4c: Psychiatry and Medical Services Outsourcing Detailed Five Year Cost**Table A.4: Option 4c: Five Year Cost Projections (FY15 Baseline Staffing)**

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$21,804,091	\$21,804,091
	Travel, Services, Commodities, Capital	-	-
	Legal	\$80,457	\$80,457
	Cost of Services	\$21,884,548	\$21,884,548
	Profit Margin	\$874,775	\$1,749,551
	Total Contract Cost	\$22,759,323	\$23,634,099
Additional Costs to State	PERS	\$120,000	\$120,000
	Contract Administration	\$3,413,898	\$3,545,115
	Total Overall Cost	\$26,293,222	\$27,299,214
	Total Cost to State	\$15,893,176	\$16,899,168

Option 4d: Nursing Outsourcing Detailed Five Year Cost**Table A.5: Option 4d Five Year Cost Projections (FY15 Baseline Staffing)**

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$66,040,172	\$66,040,172
	Travel, Services, Commodities, Capital	-	-
	Legal	\$243,688	\$243,688
	Cost of Services	\$66,283,860	\$66,283,860
	Profit Margin	\$2,649,518	\$5,299,035
	Total Contract Cost	\$68,933,378	\$71,582,896
Additional Costs to State	PERS	\$1,140,000	\$1,140,000
	Contract Administration	\$10,340,007	\$10,737,434
	Total Overall Cost	\$80,413,385	\$83,460,330
	Total Cost to State	\$44,608,547	\$47,655,492

Table A.6: Option 4d: Five Year Cost Projections (Recommended Staffing)

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$61,150,435	\$61,150,435
	Travel, Services, Commodities, Capital	-	-
	Legal	\$225,645	\$225,645
	Cost of Services	\$61,376,080	\$61,376,080
	Profit Margin	\$2,453,342	\$4,906,685
	Total Contract Cost	\$63,829,423	\$66,282,765
Additional Costs to State	PERS	\$1,140,000	\$1,140,000
	Contract Administration	\$9,574,413	\$9,942,415
	Total Overall Cost	\$74,543,836	\$77,365,180
	Total Cost to State	\$38,738,998	\$41,560,342

Option 4e: Comprehensive Outsourcing Detailed Five Year Cost**Table A.7: Option 4e: Five Year Cost Projections (FY15 Baseline Staffing)**

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$117,096,797	\$117,096,797
	Travel, Services, Commodities, Capital	-	-
	Legal	\$432,087	\$432,087
	Cost of Services	\$117,528,884	\$117,528,884
	Profit Margin	\$4,697,899	\$9,395,797
	Total Contract Cost	\$122,226,783	\$126,924,682
Additional Costs to State	PERS	\$1,737,000	\$1,737,000
	Contract Administration	\$18,334,017	\$19,038,702
	Total Overall Cost	\$142,297,800	\$147,700,384
	Total Cost to State	\$80,646,311	\$86,048,894

Table A.8: Option 4e: Five Year Cost Projections (Recommended Staffing)

		4% Margin	8% Margin
Cost of Contract	Salary & Benefits	\$110,214,531	\$110,214,531
	Travel, Services, Commodities, Capital	-	-
	Legal	\$406,692	\$406,692
	Cost of Services	\$110,621,223	\$110,621,223
	Profit Margin	\$4,421,784	\$8,843,567
	Total Contract Cost	\$115,043,006	\$119,464,790
Additional Costs to State	PERS	\$1,737,000	\$1,737,000
	Contract Administration	\$17,256,451	\$17,919,718
	Total Overall Cost	\$134,036,457	\$139,121,508
	Total Cost to State	\$72,384,967	\$77,470,019



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